Spiritual Care in an Inpatient Adolescent Co-Occurring Mental Illness and Chemical Dependency Unit: An Integrated Spiritual Care

A Professional Project

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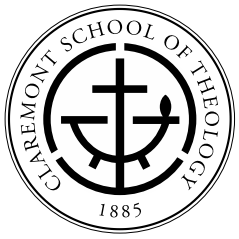

This professional project completed by

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has been presented to and accepted by the

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DOCTOR OF MINISTRY

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Abstract

In 2011 George Fitchett published an article encouraging chaplains to publish case studies as a way of articulating the intricacies of spiritual care. Since then there have been 29 published case studies and there are plans for more than a hundred to be published in the next few years. This is an attempt to provide the field of evidence-based chaplaincy research with a foundation of in depth qualitative and quantitative research. The current case studies, however, do not represent the specialty of pediatric behavioral health spiritual care. This project, utilizing the structure and design of case studies implemented by George Fitchett and Steve Nolan, will aim to articulate the distinctiveness of pediatric behavioral health spiritual care. I will begin with a review of the literature in the field. Then I will introduce three case studies from a locked inpatient adolescent co-occurring mental illness and chemical dependency unit. Lastly, I will reflect on themes within this specialty of care, as shown through the case studies, and I will highlight competencies that require a heightened state of observation. This project will bring attention to pediatric behavioral health spiritual care and will point to the need for further research into evidence-based spiritual care within pediatric behavioral health settings.

Acknowledgements

It is not without the support and influence of several individuals that I have been able to pursue and complete this project. I first want to acknowledge the academic staff who have seen this project through. My advisor, Dr. Nicholas Grier, whose insights and questions have provided rich reflection on the project's style, focus, and clarity, and whose critical reflections call into question that which is assumed or unconsciously communicated and has encouraged me to analytically imagine my interests, biases, intentions, and assessments. Professor Karen Dalton, who provided encouragement and direction to the theoretical and practical details that brought this project together. Professor Frank Rogers, whose teaching on compassionate action and reflection has informed both my practice and my self-care in a field with a heightened risk of burn out. I also want to thank Chaplain Anna Kendig, my colleague and the adult behavioral health lead chaplain. Together, we have been able to improve the quality of care provided to the 200+ behavioral health patients at our hospital through training manuels, presentations, and competency development (including Appendix B). I am also grateful to the pediatric behavioral health team for their creativity and critical thought regarding the care that we offer to vulnerable young adults. Specifically, Chaplain Mary Shaffer for her wisdom and courage to offer youth a chance to see themselves in their own healing in both practice and reflection. Further, I would like to thank the Spiritual Health Directors of my hospital during the duration of this program, Michael Doane and Chuck Ceronsky, for their ability to challenge my practice, encourage clarity, and support me during the many days that my balance between work and this project where out of sync. The Chaplains within the Spiritual Health Services Department who, for many years, have pushed the edge of the standard of spiritual care. The leaders and faculty of Trasnforming Chaplaincy and the Chaplain Summer Research Institute for an oppurtunity to

reflect on this project and my spiritual practice with faculty and peers from around the world. Finally, Caroline Park James, my spouse and lead editor, for her patience, encouragement, insights, analytical reflections, and support of the flexibility that this project has demanded.

Any part of the project that lacks clarity is due to my continued need for growth and reflection. Anything that the reader finds beneficial is due to the insight gained from one or more of the individuals above, without whom, this project would not have come together.

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Chapter 1: History and Context

In the fall of 2014 I began as a chaplain resident at a university affiliated hospital in the Twin Cities Metro Area with a clinical assignment that included an Adolescent Co-Occurring Mental Health and Chemical Dependency Unit. At the beginning of my residency I had minimal exposure to Psychiatric Chaplaincy. The brief experience I did have was from a couple visits I provided to patients on a mental health unit during my internship. I recall approaching each of these individuals with discomfort. I felt cautious about how their mental health would manifest and what, if anything, I would be able to provide for them. After a brief chart review, I remember feeling even more cautious because I was not sure what spiritual care could provide to mentally ill patients. I simply went into each visit hoping that the patients would be stable enough to have a conversation about their religious orientation and needs for support. Admittedly, I also had a hope that the visits would be quick, noting my own discomfort on the unit. One of these early visits was with a middle-aged patient who had attempted suicide after the death of their mother. It was Mother's Day when the request came in and the more we spoke about their mother the more the patient became emotional. I left that visit feeling good about giving the patient space to grieve. However, in reflection I can see how much my goals for the visit and my reflections concerning the visit were centered on my own performance.

Accompanied by stigma surrounding mental health I held a simplistic understanding of what quality outcomes for a mentally ill patient could be. On one hand, it is possible that my reflection was accurate, that the patient benefitted from a moment to grieve. On the other hand, it is also possible that the patient's tears were symptomatic rather than productive and that a conversation concerning their grief could have furthered their experience of distress and

discomfort. I will never know which outcomes occurred, but this visit highlights the intricate complexities that exist in mental health spiritual care. Similarly, case studies in chaplaincy provide a methodological approach that analyses the intricate complexities of a chaplain-patient interaction.

The practice of case reflection has deep roots within the field of chaplaincy. Anton Boison, often referred to as a founder of modern chaplaincy and CPE in the US, utilized a method of case study research as a central part of his work.[1] He took scrupulous field notes concerning what he called, "living human document[s]" and he founded the practice of action-reflection-action learning as understood within clinical pastoral education today. Simply put this method of learning requires that an individual be mindful of their actions, contexts, biases, intentions, emotions, and experiences to the extent that they take thorough notes (often in the form of a verbatim) to reflect upon their practice and wonder what, consciously and subconsciously, informed their decisions. Then, after reflection, the practicing chaplain can perform more thoughtful action. While Boison referred to this practice as case study research, chaplaincy has not engaged in formal case study research until recently. George Fitchett, a leading researcher in the field, claims that the first case study to meet research standards was written by Rhonda Cooper in 2011.[2] There are noteworthy depictions of chaplain reflections in writing, recorded interviews, and within other forms of publication.[3] However, Fitchett argues,

[1] For a brief overview of Anton Boison's contributions to chaplaincy see: George Fitchett, "Introduction," in *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy*, George Fitchett and Steve Nolan, eds. (London: Jessica Kingsley Publishers, 2015), 13.

[2] Fitchett, "Introduction," 13, 21.

[3] For an example, see: "Stories of Chaplaincy," Cincinnati Children's, accessed October 15, 2018, https://www.cincinnatichildrens.org/education/clinical/specialty/sub-res/pastoral/stories.

these vignettes do not engage the in-depth analysis that is needed in a qualitative case study project.

Since the original publication in 2011 by Rhonda Cooper, Fitchett and Steve Nolan have been the editors of 24 out of the 29 published case studies. Their intention has been to develop a field of case study research that can inform chaplaincy education, future research initiatives, and spiritual care theory. They also share a broader goal to provide medical staff and interdisciplinary members with cases that help articulate what happens in a spiritual care visit.[4] Case study research parallels the action-reflection-action model of clinical pastoral education with methods of research that can turn a chaplain's retelling of a story (verbatim) into a qualitative analysis of the care provided.

In an article titled "Making Our Cases," Fitchett argued that chaplains do not have enough theory or data to begin quantitative evidence-base research.[5] Since then there has been a growing number of qualitative and quantitative research studies written by or with the influence of a chaplain. Still, with only 29 published case studies there is not a clear understanding of what a chaplain-patient interaction entails. Chaplains therefore need to make themselves known through case studies, highlighting the uniqueness of care provided across disciplines and articulating specialties in the development of a coherent depiction of chaplain practice.

It is the goal of this project to make the case for the distinctiveness of pediatric behavioral health spiritual care (PBHSC) by first describing the background for PBHSC using a brief

[4] George Fitchett, "Making Our Cases," *Journal of Healthcare Chaplaincy* 17, no. 1-2 (April 2011): 3-18, https://doi.org/10.1080/08854726.2011.559829.

[5] Fitchett, "Making Our Cases."

literature review of chaplain published research.[6] I will then describe my own theoretical approach to PBHSC by presenting three case studies from a locked inpatient unit. Then I will engage in a reflection of theory and practice in a discussion of the case studies to highlight the uniqueness of PBHSC.

Before I can describe what has been written in PBHSC, I will provide some contextual details including the background of my own clinical practice and definitions of key terms I will be utilizing throughout this project. I will first begin with some definitions.

Key Definitions

Present research on spiritual care lacks a consensus on definitions for terms such as religion and spirituality, or chaplaincy and spiritual care. For example, depending on the research study some authors discuss the concept of religiosity and spirituality as interchangeable terms and some authors describe the distinctions between each. The problem is further complicated by the diversity of researchers contributing to the field of spiritual care. While the number of chaplain researchers is increasing there remains more research outside of the field of chaplaincy contributing to the field of spirituality and health.[7] Therefore, chaplain researchers find themselves attempting to catch up in a field of research that discusses their area of expertise but lacks their influence. It is therefore important to state the definitions I will be using to be clear about how I am approaching this project and the care that I provide to my patients.

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[6] I will utilize the abbreviation PBHSC throughout this project to represent Pediatric Behavioral Health Spiritual Care.

[7] For example, see: Helen Land, *Spirituality, Religion, and Faith in Psychotherapy: Evidence-Based Expressive Methods for Mind, Brain, and Body* (Chicago: Lyceum Books, Inc., 2015); Harold G. Koenig, *Religion and Mental Health: Research and Clinical Applications* (London: Elsevier Inc., 2018); Harold G. Koenig, *Spirituality in Patient Care: Why, When, and What,* 3rd ed. (Pennsylvania: Templeton Press, 2013).

First, I do not use the words spirituality and religion interchangeably. Instead, I see a clear distinction between the two. For the sake of consistency within the field of chaplaincy I will use definitions that have developed through an interdisciplinary consensus project. Led by the efforts of Dr. Christina Puchalski, an interdisciplinary palliative care team met to review and articulate definitions of spirituality in relation to the medical field. The resulting definitions are used by the hospital I work for and have been recently published in a handbook titled *The Impact of Professional Spiritual Care*.[8] The consensus definition of spirituality is:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.[9]

This definition is inclusive of religion but not dependent on religion for a person to find significance in their spirituality. In an attempt to further clarify the distinctiveness of religion from spirituality, the handbook on the *Impact of Professional Spiritual Care* uses a definition published by Psychiatrist Harold G. Koenig who has hundreds of peer-reviewed articles and over 40 books published in the field of spirituality, religion, and health. The definition of religion used is:

> Religion is "an organized system of beliefs, practices, rituals and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power or ultimate

[8] This handbook is a joint publication of ACPE: The Standard for Spiritual Care & Education, Association of Professional Chaplains, Canadian Association for Spiritual Care, National Association of Catholic Chaplains, Neshama: Association of Jewish Chaplains. See: "The Impact of Professional Spiritual Care," Association of Professional Chaplains, accessed December 2, 2018, http://www.professionalchaplains.org/content.asp?pl=86&sl=875&contentid=875.

[9] Christina M. Puchalski, et al., "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17, no. 6 (May 2014): 646, https://doi.org/10.1089/jpm.2014.9427.

> truth/reality) and (b) foster an understanding of one's relationship and responsibility to others in living together in a community."[10]

I find both definitions beneficial to the field of chaplaincy as they provide a potential foundation for the meaning of spirituality and religion in the development of theory related to chaplaincy. Though neither of these definitions are exhaustive, nor specific to any context, they can provide needed consensus to a field otherwise disoriented by the number of distinct and sometimes contradictory definitions for both spirituality and religion. To capture the intricacies of any spirituality, the chaplain researcher will need to provide insights into the limitations and/or variations of the definitions as necessary. Therefore, additional research can strengthen these definitions with each finding, alteration, or clarification learned from the multiplicity of spiritualities that practice spiritual care and receive spiritual care.

Along with the distinctions between spirituality and religion it is important to clarify that spiritual care and chaplaincy are not always interchangeable. While many publications use these terms interchangeably, they do not always represent the same thing. For example, Paul Nash describes chaplain models as multifaith, interfaith, and generic spiritual care in order to depict the pros and cons of each approach.[11] The *Impact of Professional Spiritual Care* notes that "Chaplains are spiritual care practitioners, but not all spiritual care practitioners are chaplains."[12] I view my practice as spiritual care but I will utilize the term *chaplaincy* as it is the field of theory and practice that informs my own understanding of spiritual care.

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[10] Harold G. Koenig, et al., *Handbook of Religion and Health* (New York: Oxford University Press, 2001), quoted in "The Impact of Professional Spiritual Care," 5.

[11] Paul Nash, Mark Bartel, and Sally Nash, eds., *Paediatric Chaplaincy: Principles, Practices, and Skills* (London: Jessica Kingsley Publishers, 2018), 62-64.

[12] "The Impact of Professional Spiritual Care," 3.

While offering a foundation for the context of chaplain theory and practice, these definitions are not exhaustive and do not highlight the unique needs of each specialization. I do not believe that the answer is to write new definitions but to evolve these definitions for the unique needs of each care population. For example, the patients that I work with would not understand what is meant by Puchalski's consensus definition, but a shortened version describing spirituality has been beneficial to my practice. I start most of my spirituality groups with the following definition, "Spirituality is simply how you do (or do not) feel connected to who you are; how you do (or do not) make meaning of all that is going on around you; and how you do (or do not) take care of yourself in the midst of all of this." As the spiritual caregiver I offer this translated version of the consensus definition to teach patients what spiritual health may mean to their healing process.

It is also important to define adolescents. This paper will specifically focus on the age range of 13-to-18-year-old patients as this is the age range of the unit of this project's focus. This is important to note as some authors such as Daniel J. Siegel and Paul Nash describe adolescence as an age ranging up to 26, however, for the developmental context and significance of this project I will utilize the age range of the patients on the unit.

Lastly, it is important to describe what is meant by mental health, behavioral health, and psychiatric care. The phrase behavioral health is used by my hospital as an umbrella term to describe individuals suffering from mental illness, chemical dependency, and the behavioral effects of each. There are benefits to these terms as they reference the broad range of behaviors included in the intersection of chemical dependency and mental illness and they support methodologies that focus upon behavioral changes to support one's wellbeing (i.e. cognitive behavioral therapy, dialectical behavioral therapy, etc.). This emphasis on behaviors, however,

can sometimes miscommunicate the role of symptomatic responses in a patient's behaviors. By doing so, this can make it sound as though the patient is inherently responsible for their mental illness and addiction problems and increase the stigma surrounding behavioral health care. Some alternatives include psychiatric care or co-occurring mental illness and chemical dependency. While behavioral health care is a type of psychiatric care, it is itself unique as it utilizes a mixture of medication management, therapeutic interventions, and integrative modalities. For this reason, I will continue to use the phrase behavioral health throughout this paper as I describe the care provided on my units.

Spiritual Care Context

I began my chaplain residency covering a single pediatric behavioral health unit, as well as two pediatric medical and surgical units. As a part of my standard practice I led one, one-hour long group a week on a locked co-occurring mental illness and chemical dependency unit. To establish structure for the patients, the unit makes all the interdisciplinary groups (psychotherapy and psychoeducation therapeutic groups), including spirituality group (psychoeducation). Outside of the group, individual support can be requested by patients or by myself or the clinical care team if assessed as beneficial. During my residency, the spiritual care provided on this one unit was noticed and requested by other pediatric psychiatry units. Four years later, our spiritual health services department provides 2.45 full-time equivalency (FTE) chaplains to cover pediatric psychiatry units. Our team of three covers inpatient, outpatient, and residential units of varying acuity levels and different primary care foci (i.e. chemical dependency and/or stabilization of mental health).

The hospital's foundation decided to increase the FTE of the spiritual care team reflecting the belief that chaplaincy is an effective method of care for patients, and one that the unit staff

supports. However, it was not clear what made it effective. Unit staff and patients began requesting chaplains by name. Comments like, "Can you send ____? We really appreciate their approach more so than the other chaplain we experienced" became common amongst the staff. This lack of staff insight about chaplaincy approaches and interventions led us to publish several articles describing chaplaincy in the pediatric behavioral health newsletters.[13] In addition, our groups are considered part of the unit methodology and therefore, they are billable. The billable nature of our groups is both a unique benefit compared to chaplain programs in other hospital systems and it has pushed our team to write detailed curriculum identifying the intended outcomes for each group and how the outcomes will be measured. All of this to say that working within PBH units has directly affected how to articulate the practice of spiritual care.

In total, the team of pediatric BH chaplains covers 70 plus inpatient beds, 10 plus residential beds, and 100 plus outpatient openings. The team leads leading an average of 18 one-hour long spirituality groups a week and 30 plus individual sessions.[14] The age range on these units is between 5-year-old patients to 26-year-old patients with an acuity of symptoms and cases ranging from crisis intervention (first time experiences with mental health symptoms or diagnoses) to a mental health inpatient intensive care unit for children and adolescents.

As noted above, this project will focus on the adolescent co-occurring mental illness and chemical dependency inpatient unit. The unit has 20 beds with an average stay of 5 to 7 days. The patients vary in acuity from mild to severe mental health, chemical dependency, and behavioral issues. I have been the chaplain on this unit for four and a half years. I lead a one-

[13] See Appendix A for newsletter articles used to articulate spiritual care in pediatric behavioral health units.

[14] We are a small team of chaplains at an 800 plus bed university affiliated hospital in the Twin Cities metro area.

hour long spirituality group a week and engage in three to five individual conversations a week with patients. My time on the unit is limited to that of a part time staff member as I work in our residential and outpatient units as well. When youth are recommended to the residential program and/or an outpatient program, I establish a relationship based upon continuity of care and follow the clients through completion of their treatment program.

The Chaplain

For the case studies included in Chapter 3, I will utilize a method of analytic autoethnographic research, explained further in Chapter 2. However, it is important to describe my own context at this point since I will be both researcher and subject in this case study project. Nolan writes that chaplain researchers using analytic autoethnography as a method must "make use of their subjective self in explicit and reflexive self-observation, and thereby produce what is in effect a narrative of the self."[15] Therefore a chaplain case study that looks at the phenomenon of spiritual care practice is often more reflective of the practice offered by the chaplain than about the patient's self. This, then, further emphasizes the need to include and understand the chaplain's context.

I will be the chaplain in the three cases presented. Though a multi-study involving the practice of other PBH chaplains would be beneficial, the purpose of this project is primarily to highlight the uniqueness of the context through the reflection of individual cases. I am a 30-year-old straight, married, white, cisgender male. My wife and I own a home and we are socio-economically middle class. I have no identified mental health diagnoses but have had episodes of anxiety and depression and have an experience of childhood trauma. I come from a Christian

[15] Nolan, "Introduction," 18.

family background and a lot of my spiritual development has been rooted within Christianity. I am ordained and endorsed for chaplaincy and I identify as a Humanist Christian. I have been a practicing chaplain for four and a half years working primarily in PBH. I am now the PBH team lead for the Spiritual Health Services department and I have worked closely with the Adult BH lead to develop trainings, offer presentations, and renovate the behavioral health competency standards for the spiritual health department. While the demographics listed above may begin to describe aspects of my spiritual care practice and approach, I consider Emmanuel Lartey's description of human personhood, "That every person is in some respect: 1) Like all others 2) like some others and 3) like no others."[16] This description informs my spiritual care practice and approach to all individuals. It emphasizes a level of curiosity that I use in assessment and interventions as I work closely with the needs of individuals from various contexts (cultural, societal, and inter- and intra- personal).

Lastly, I took a different route to chaplaincy than most chaplains. I did not receive my M.Div. but rather a M.Th. in Theology and Ethics. I believe that this degree has informed the way that I look at chaplaincy and spiritual care with a critical eye and it has informed my desire for chaplaincy as a field to find clinical articulations for the praxis that is developed for and with each unique clinical setting.

The above does not capture all that I am or am not in my spiritual care practice. Therefore, I will attempt to add necessary and informative details concerning my context throughout the case study data and analysis.

Challenges of Mental Health Chaplaincy

[16] Emmanuel Y. Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed. (London: Jessica Kingsley Publishers, 2003), 34.

The problem of articulating the uniqueness of each clinical setting is the central problem that informs this project. For my context the question is: What is PBHSC and how it is unique from other forms of spiritual care? First, the complexities within PBHSC necessitates paying attention to mental health symptomatic responses not often taught within clinical pastoral education. The attentiveness to needed training is a response to the increasing need for evidence-based practices within chaplaincy.

In the introduction of *Evidence-Based Healthcare Chaplaincy*, Fitchett, et al., share two main reasons for why chaplaincy needs to embrace an evidence-based model. The first is that "health care is an evidence-based activity" in which chaplains work and are evaluated within. More importantly, they argue, "we need research to help us know if the care we are providing is having the effects we hope it will have."[17] Without knowledge of the effects of our care we may, at best, be providing ineffective care at the expense of the healthcare system; and, at worst, we may be causing harm to the patient. In visits of complexity, including but not limited to mental health visits, not knowing a patient's symptomatic issues may cause the chaplain to be more likely to provide ineffective or harmful interventions.

For example, during my residency I worked closely with a patient who responded well to conversations with me and had requested that I visit frequently if able. I visited three times a week. The patient spoke about significant areas of meaning-making, dynamics of their faith narrative, curiosities regarding new coping strategies for their developing diagnosis of anxiety, and more. Unknown to me, they had stopped working as closely with the unit staff. They did not

[17] George Fitchett, et al., eds., *Evidence-Based Healthcare Chaplaincy: A Research Reader* (London: Jessica Kingsley Publishers, 2018), 12-13.

participate with their therapist and they did not engage well with other patients in group therapy. When I asked about their lack of engagement, they shut me out and refused further visits.

At that time, the unit had a higher census and more acuity than it had been used to, and our communication as a unit was not as strong as it could be. As we debriefed this patient's experience and their three weeks stay on the unit, we realized that the symptoms of the patient's borderline personality disorder (BPD) had split the interdisciplinary team between me and everyone else. The care I was providing became a hindrance to the patient's interactions with the interdisciplinary team and potentially led to the extension of their hospitalization. At the time, I had received limited training regarding spiritual care and BPD so I showed up as I would to any other visit influenced by a Rogerian approach of meeting a patient where they are at. I was also a resident who felt flattered and appreciated by the patient's response to the care I provided.

I have learned through experience and networking that the inclusion of spiritual care for mental health settings is not a standard practice in chaplaincy but a responsive practice. Similarly, there is not a standard of training within clinical pastoral education that includes mental health competencies and spiritual care. The irony of this is in chaplaincy's roots in the work of Anton Boison, someone who worked within mental health units and reflected extensively on his own mental health challenges.[18] I have spoken with a number of chaplains, most recently at the Chaplaincy Research Summer Institute run by Transforming Chaplaincy, who communicate being under prepared, needing to write/create their own standards of practice,

[18] See: Anton T. Boison, *Out of the Depths: An Autobiographical Study of Mental Disorder and Religious Experience* (New York: Harper and Brothers, 1960).

and needing to think creatively about what mental health chaplaincy can be.[19] Alongside a colleague of mine, it has been an important part of my practice to develop and implement standards for PBHSC that is taught to all staff and students (Residents and Interns). These competencies cover safety, interventions, and outcomes based on acuity levels, differences between disciplines, and more information concerning the chaplain's role and practice with a patient suffering from mental health challenges.

Justification for Research

There are two significant factors in the descriptions above: First, it is unclear what mental health chaplaincy is and what mental health chaplains do. Second, chaplains who work in mental health settings must write their own standards of care and implement a practice that responds effectively to the symptomatic challenges within the units they serve.

The role of a psychiatric chaplain distinctly challenges the chaplain to articulate the breadth of spiritual health as it reaches beyond the mechanisms of religiosity. In a number of interviews, John Swinton talks about having his perspective on health, humanness, and spiritual care change from his experiences as a nurse and later a chaplain working with patients who suffered from mental health problems.[20] I have also experienced my work in mental health care as formative to my understanding of what spiritual care can be. I began to see the spiritual needs of patients that could not be met with silent presence (Rogerian view of chaplaincy) or from

[19] There is a training for chaplains in mental health practice that is created for and facilitated within the context of the U.S. Department of Veterans Affairs. See: "Mental Health Integration for Chaplain Services," U.S. Department of Veterans Affairs, accessed December 2, 2018, https://www.mirecc.va.gov/mentalhealthandchaplaincy/mhics.asp.

[20] For example, see: Duke Divinity School, "John Swinton: Taking our Meds Faithfully?" filmed March 2017, YouTube video, 26:07 (October 24, 2017), https://www.youtube.com/watch?v=t1IH4BJ08PQ&feature=youtu.be.

religious support. I think of a young man who could not see the connection between new therapeutic skills and his personal values. In this simple example the role of the chaplain was the integration of his personhood with his overall goals of care/medical realities, connecting his meaning-making with his care. Integration of his personhood relates to how an individual connects their self with the illness they are experiencing. Another example is a young man who found yoga beneficial for his anger, but had a difficult time seeing himself as someone who would practice yoga. We worked to integrate the potential of his new skills with the values of his personhood. I also think of a young woman who defined forgiveness as "bullshit, bullshit, bullshit" following two experiences; one experience of trauma and one of complex grief associated with an abortion. She understood forgiveness as "being the bigger person and accepting an individual's apology." We worked to reframe forgiveness as a practice of self-healing, honoring her own pain, in its many forms. We co-created opportunities for her to honor and practice both grief and forgiveness. We connected this work to her journey away from experiences with her childhood theology, which she found unhelpful, into a journey of her own spiritual discovery.

In both of these stories the patients did not explicitly value religion and both were working to heal from some experiences of religion. Their primary spiritual needs were honoring their values, reframing deep areas of their present meaning-making (i.e. forgiveness), and developing news coping skills that utilized their personal agency. Using these stories, therefore, exemplifies the need for a definition of spiritual health that gets at the core of an individual's own unique spirituality, as offered by Puchalski's consensus definition. I believe that the core is their connection(s), their meaning-making (articulating their experiences and worldview), and

their purpose (finding what drives or motivates them), exemplified in the ways they do, or do not use their agency in their healing and recovery.

This project will articulate the distinctiveness of PBHSC through examples of my practice. I hope to highlight the unique needs within PBH populations, as I have experienced them. I also hope to highlight the importance and value of chaplaincy to these populations so that interest may surface into further studies that will support this specialization.

Chapter 2: Pediatric Behavioral Health Spiritual Care

Existing research in this field is limited. A literature search for articles written by chaplains in the field of pediatric psychiatry produces fewer than ten articles. There are more articles published in spiritual care/chaplaincy and mental health, but the specification of pediatrics greatly reduces the results. A significant number of the articles are written by or with Daniel H. Grossoehme during his time working on an adolescent inpatient psychiatry unit. Grossoehme added information to a specialization that was otherwise void of chaplain authorship. His methodology in at least four of his articles utilized a patient self-reported valuation through surveys and interviews.[21] Published between the years of 2001 and 2007, these early articles contributed clarity regarding a chaplain's influence in a patient's PBH healing narrative, as well as, patient and staff perceptions of chaplain interventions. Grossoehme has continued to become a lead researcher in the field of chaplaincy.

Since 2007 he has shifted his research interests to reflect his clinical placement with cystic fibrosis patients. While his research has shifted with his clinical focus, he has continued to

[21] Daniel H. Grossoehme, "Self-Reported Value of Spiritual Issues Among Adolescent Psychiatric Inpatient," *The Journal of Pastoral Care* 55, no. 2 (June 2001): 139-145, https://doi.org/10.1177/002234090105500203; Terri R. Chapman and Daniel H. Grossoehme, "Adolescent Patient and Nurse Referrals for Pastoral Care: A Comparison of Psychiatric vs. Medical-Surgical Populations," *Journal of Child and Adolescent Psychiatric Nursing* 15, no. 3 (2002): 118-123; Daniel H. Grossoehme and Lawrence Gerbetz, "Adolescent Perceptions of Meaningfulness of Psychiatric Hospitalization," *Clinical Child Psychology and Psychiatry* 9, no. 4 (October 2004): 589-596, https://doi.org/10.1177/1359104504046162; Daniel H. Grossoehme, et al., "Spiritual and Religious Experiences of Adolescent Psychiatric Inpatients versus Healthy Peers," *The Journal of Pastoral Care and Counseling* 61, no. 3, (September 2007): 197-204, https://doi.org/10.1177/154230500706100304.

investigate mental health aspects of patient's overall healing.[22] These studies do not address mental health diagnoses specifically but rather highlight spirituality as a supportive factor to someone suffering from mental health problems.[23] For example, Grossoehme, with a team of researchers, evaluated adolescent spirituality and treatment adherence in regard to cystic fibrosis. Although findings from this study on physical health have an underlying meaning for patients in mental health treatment programs, additional research is needed to support the idea that spirituality, and chaplaincy, can support a patient's adherence to treatment in any setting.

Grossoehme's studies use assessment tools to generate a patient-reported method determining the value of spirituality by patients.[24] Though not explicitly noted in the articles the factor of youth culture, as context, plays a significant role in any self-reported study. As culture changes, so do understandings of words such as spirituality, god, and religion. Therefore, the shifting cultural/societal understandings of these terms distort the effectiveness of these studies and the tested efficacy of any assessment tools used within them.

Further, the articles did not explicitly note how terms such as *spirituality* were defined to the patient's being surveyed or interviewed. By not defining terms like *spirituality* to patients I

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[22] Daniel H. Grossoehme, et al., "Adolescents' Spirituality and Cystic Fibrosis Airway Clearance Treatment Adherence: Examining Mediators," *Journal of Pediatric Psychology* 41, no. 9 (October 2016): 1022-1032, https://doi.org/10.1093/jpepsy/jsw024; Yuanshu Zou, et al., "Documenting an Epidemic of Suffering: Low Health-Related Quality of Life Among Transgender Youth," *Quality of Life Research* 27, no. 8 (August 2018): 2107-2115, https://doi.org/10.1007/s11136-018-1839-y; Antonia T. Kopp, et al., "Body Sanctification and Sleep in Adolescents with Cystic Fibrosis: A Pilot Study," *Journal of Religion and Health* 56, no. 5 (May 2017): 1837-1845, https://doi.org/10.1007/s10943-017-0415-z; Daniel H. Grossoehme, et al., "Screen for Spiritual Struggle in an Adolescent Transgender Clinic: Feasibility and Acceptability," *Journal of Health Care Chaplaincy* 22, no. 2 (February 2016): 54-66, https://www.tandfonline.com/doi/full/10.1080/08854726.2015.1123004.

[23] The term "mental health problems" will be used throughout this study in reference to symptoms or episodes of mental illness or a mental health imbalance that does not constitute a mental health diagnosis.

[24] Grossoehme, "Self-Reported Value;" Grossoehme, "Adolescent Perceptions."

believe that the methodology is vague and open to inconsistent definitions. While terms like *spirituality* were described for the reader, it was not clear how Grossoehme introduced the topic of spirituality to patients/participants. In an article that created and tested a new spiritual screening tool one chaplain observed that a patient became agitated by the survey itself when asked questions about god and spirituality.[25] This highlights the need to describe these terms so that each participant knows what may or may not be meant by the research question, therefore limiting triggered responses to broad terms like god and spirituality. This study, as well as some of the others, continued to identify the challenges and potential limitations of research within adolescent psychiatry.

Outside of peer reviewed articles there are a few books with chapters that highlight pediatric spiritual care. A multi-disciplinary publication featuring Grossoehme discusses the relation between adolescent spirituality and health, briefly highlighting the role of mental health in a patient's overall physical wellbeing.[26] More directly related is a chapter in *Paediatric Chaplaincy: Principles, Practices, and Skills*. Kathryn Darby offers an overview of what spiritual care can offer pediatric patients suffering from mental health problems.[27] This chapter is a significant contribution to the field as it offers an overview that has not previously been published by a chaplain working in PBHSC. However, there are few brief clinical examples of the spiritual care provided and the chapter is, therefore, primarily a chapter on theory of practice.

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[25] Daniel H. Grossoehme, "Development of a Spiritual Screening Tool for Children and Adolescents," *The Journal of Pastoral Care and Counseling* 62, no. 1-2 (March 2008): 71-85, https://doi.org/10.1177/154230500806200108.

[26] Sian Cotton, et al., "Religion/Spirituality and Health in Adolescents," in *Spirit, Science, and Health: How the Spiritual Mind Fuels Physical Wellness*, Thomas G. Plante and Carl E. Thoresen, eds. (London: Praeger Publishers, 2007), 143-156.

[27] Kathryn Darby, "Working in Mental Health," in *Paediatric Chaplaincy: Principles, Practices, and Skills*, Paul Nash, Mark Bartel, and Sally Nash, eds. (London: Jessica Kingsley Publishers, 2018), 177-189.

Beyond the resources mentioned above, a researcher would not find many references to spiritual care in pediatric mental health settings. For example, there are two paragraphs in *Spiritual Care with Sick Children and Young People* that reference mental health care but speak to a minimal level of involvement by the chaplain.[28] They suggest that this is a field in need of further research that contributes to the value of spiritual care practice in pediatric mental health settings.

The benefit of the articles and chapter mentioned above is the overall positive reporting of spiritual care to patients with mental health problems. Though further articulation of theory and practice is needed the narratives from the above research projects and the overviews offered show positive experiences of spiritual care. Spiritual care can be further articulated as a central modality for a patient's healing from mental health problems.

Spiritual Care and Psychiatry

Beyond publications written by chaplains themselves there is an interest in research focused on spirituality/religiosity and pediatrics. There has been growing interest in this field for the past two decades focusing upon the significance of spirituality in an individual's overall wellbeing. These studies continue to show an inverse affect between a patient's spirituality or religiosity and their mental health problems, highlighting the importance that spiritual care can provide. The challenge with these studies is that most of them emphasize the spiritual care support that can be offered by a generalist, unaware of the specialty that a chaplain can bring to a mental health patient's care.

[28] Paul Nash, Kathryn Darby, and Sally Nash, *Spiritual Care with Sick Children and Young People: A Handbook for Chaplains, Paediatric Health Professionals, Arts Therapists and Youth Workers* (London: Jessica Kingsley Publishers, 2015).

Theoretical Development

The limited research in the field of PBHSC has encouraged the development of the spiritual care I practice on my units. My colleagues and I have developed some standards of practice for mental health chaplains. We have begun articulating the interventions and outcomes we use in our daily practice. And, we have had to articulate the purpose of each spirituality group, including how we would measure the outcomes received. We have worked closely with behavioral health management to establish our group curriculum and to further articulate our outcomes of care. We have also focused our efforts on training behavioral health employees, both chaplains and members of the interdisciplinary team. Often it is in this training that staff are trained to notice the intricacies between spiritual care generalist and spiritual care specialists.[29] All of these efforts have been in response to a lack of articulated praxis, encouraging myself and my colleagues to review and describe what it means to seek spiritual healthiness.

Swinton offers an in-depth reflection on the how his understanding of spirituality and religion was adapted by working with individual's mental wellbeing. He writes, "Spirituality is a dimension in the lives of all of those to whom we seek to offer care. As such, being prepared to care for this aspect is not a choice but a necessity for mental health caregivers who seek to care for persons in all of their fullness."[30] Given that spiritual care is a primary aspect of a patients wellbeing, then chaplains must be effectively trained and prepared to be an impactful part of patient care in mental health settings. Not only responding to issues of grief, spiritual distress, or

[29] See Appendix B, which features a document that my colleague Anna Kendig and I created to articulate the differences between disciplines. This document is primarily used in our Behavioral Health Orientation for incoming Staff and Chaplain Residents.

[30] John Swinton, *Spirituality and Mental Health Care: Rediscovering a 'Forgotten' Dimension* (London: Jessica Kingsley Publishers, 2001), 36-37.

religious ritual support, chaplains must also imagine ways to integrate an individual's spiritual self into the process of the detox unit, the intensive care mental health unit, the stabilization unit, or the long-term treatment center. The current literature in PBHSC does not offer an in-depth analysis of what interventions could be supportive in these settings but it does indirectly support a stepping back until patients are at their baseline. Paul Nash, Sally Nash, and Kathryn Darby talk about interventions as establishing rapport in mental health settings. However, they cover this topic by briefly noting it as an exception to standard practice and not a chaplain's primary clinical focus.[31]

In my hospital, I am one of three chaplains assigned as the primary chaplains to PBH units. We also have clinical assignments in outpatient and residential treatment centers, but the care offered in outpatient and residential is often more welcomed than the care offered in inpatient stabilization units. That is why I have chosen my locked, inpatient co-occurring mental illness and chemical dependency unit as the focus of this project. I want to highlight what chaplaincy can offer on an inpatient stabilization unit when there is adequate training for attending to mental health dynamics. This includes the challenge of choosing what to address during a patient's hospitalization and choosing what *not* to address. Chaplains are often trained to follow a patient's lead and discover what the needs are with the patient. Nash, Nash, and Darby write, "the child leads the adult into realms of discovery and meaning, revealing their spiritual life, sharing their inner world."[32] Our visits are still deeply rooted in a mutual discovery of meaning and connection but occasionally the chaplain must decide when to limit the discovery for the sake of the unit's goals for stabilization and discharge.

[31] Nash, *Spiritual Care,* 97.
[32] Nash, *Spiritual Care,* 27-28.

For example, there was a young woman who was admitted to my unit after a suicide attempt. She was having trauma symptoms (flashbacks, nightmares, and dissociative moments) and was diagnosed with general anxiety disorder and major depressive disorder. She explained to the doctor that she had attempted suicide because of her grief regarding her grandfather. The team also discovered that her step-dad had died the year prior and her brother had completed suicide a year before that. In consultation with the unit staff it became clear that any discussion of her grief further stimulated her symptomatic responses. Allowing her to have space to discuss her grief would arguably be beneficial. However, we decided as a team that due to the nature of her symptomatic responses, I would not have a meeting with her to discuss her grief but would rather introduce grief on an educational level. The case manager then worked to get her set up with a grief counselor who also specialized in trauma. PBHSC mandates this level of analysis to determine what will be beneficial for each patient, focusing on their stabilization as the primary goal of the hospitalization.

Spiritual Care in Case Studies

After Fitchett presented the call for writing case studies, he has worked with Steve Nolan in the editing of 24 out of 29 published case studies.[33] These 24 case studies are distributed amongst two books and a special edition of *Health and Social Care Chaplaincy*. There have also

[33] There are nine case studies published in two books and a special edition journal article with six more case studies: George Fitchett and Steve Nolan, eds., *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy* (London: Jessica Kingsley Publishers, 2015); George Fitchett and Steve Nolan, eds., *Case Studies in Spiritual Care: Healthcare Chaplaincy Assessments, Interventions, and Outcomes* (London: Jessica Kingsley Publishers, 2018); George Fitchett and Steve Nolan, eds., "Chaplain Case Study Research," special issue, *Health and Social Care Chaplaincy* 5, no. 2 (2017): 167-329.

been four case studies published by the *Journal of Health Care Chaplaincy*.[34] The case studies range in specializations, including oncology, palliative care, psychiatry, pediatrics, and more. The patients in the case studies range in age from just 2-years-olds to those in their 80s. These cases also come from a variety of contexts including the US, Canada, the UK, Israel, Germany, the Netherlands, and Australia. While 28 of these case studies can be read in English one of the case studies is published in Hebrew.[35] These case studies provide valuable information to the field of chaplaincy in the development of an articulated theory and practice with which evidence-based research can be built upon.

There are continued efforts to publish more case studies as foundational expressions of the work of spiritual care. In the Netherlands there is a case study project that hopes to publish 120 spiritual care case studies by the year 2020.[36] The case studies already published and those yet to be published will continue to add insight into the particularities of spiritual care practice while also highlighting the coherence between specialties. However, it is important that various

[34] Rhonda S. Cooper, "Case Study of a Chaplain's Spiritual Care for a Patient with Advanced Metastatic Breast Cancer," *Journal of Health Care Chaplaincy* 17, no. 1-2 (April 2011): 19-37, https://doi.org/10.1080/08854726.2011.559832; Stephen D. W. King, "Facing Fears and Counting Blessings: A Case Study of a Chaplain's Faithful Companioning a Cancer Patient," *Journal of Health Care Chaplaincy* 18, no. 1-2 (April 2012): 3-22, https://doi.org/10.1080/08854726.2012.667315; James L. Risk, "Building a New Life: A Chaplain's Theory Based Case Study of Chronic Illness," *Journal of Health Care Chaplaincy* 19, no. 3 (July 2013): 81-98, https://doi.org/10.1080/08854726.2013.806117; Steve Nolan, "He Needs to Talk!": A Chaplain's Case Study of Nonreligious Spiritual Care," *Journal of Health Care Chaplaincy* 22, no. 1 (January 2016): 1-16, https://doi.org/10.1080/08854726.2015.1113805.

[35] M. Schultz, "So that there will be one good and true thing to say about me in my eulogy," in *Meeting in the Midst: Spiritual Care in Israel*, N. Bentur and M. Schultz, eds. (Jerusalem: JDC Israel-Eshel, 2017), published in Hebrew, so far untranslated.

[36] Martin Walton and Jacques Körver, "Dutch Case Studies Project in Chaplaincy Care: A Description and Theoretical Explanation of the Format and Procedures," in "Chaplain Case Study Research," George Fitchett and Steve Nolan, eds., special issue, *Health and Social Care Chaplaincy* 5, no. 2 (2017): 259.

specialties are written about in order to gain a greater understanding of, and make greater use of, what chaplains offer. In this light Fitchett writes:

> Case studies provide the opportunity to build a body of research that, over time, can be used to interrogate chaplaincy and spiritual care practice, and to inquire, for example, whether certain interventions work more effectively with certain types of patients.[37]

I therefore offer this project as an addition to the field of published case studies, highlighting the uniqueness of pediatric behavioral health spiritual care. These case studies are not meant to be generalizable but are meant to add opportunities for further research through continued analysis of PBHSC as a specialty.

Methods

In a recent article Nolan explains that when a chaplain writes a case study, they write through the lens of an analytic autoethnography. Like ethnography studies, this type of methodology utilizes an awareness of the self with the ethnographer's surroundings. An analytic autoethnography, "entails the kind of self-conscious introspection that is guided by a desire to better understand both self and others through examining one's actions and perceptions in reference to and dialogue with those of others."[38] Nolan uses analytic autoethnography to describe the way a chaplain gathers, engages with, and writes a case study.

Nolan and Fitchett have additional publications that describe methodologies for case study research citing Robert E. Stake and Robert K. Yin as well as other supplementary

[37] Fitchett, "Chaplain Case Study Research," 169-170.

[38] Steve Nolan, "Introduction: Autoethnography in Chaplain Case Study Research," in *Case Studies in Spiritual Care*, George Fitchett and Steve Nolan, eds. (London: Jessica Kingsley Publishers, 2018), 18.

sources.[39] For the benefit of consistency I have structured my case studies in the way that Fitchett and Nolan describe in the many publications.

Nolan presents Stake's differentiation of case study projects as either instrumental or intrinsic. I believe my case study project will be both intrinsic and instrumental. Nolan summarizes Stakes theory: "Intrinsic interest in a case is motivated by the intention to gain better understanding of this particular case; in a related way, instrumental interest in a case aims at developing insight into a specific issue or aspect of theory."[40] I believe that my project will be intrinsic with the goal to gain a better understanding of the spiritual care I am providing, therefore contributing to the field of PBHSC as an instrumental study as well.[41]

Making My Cases

This project will introduce three individuals: Michael, a young African-American man with a significant social and psychiatric background. Sara, a young Caucasian woman with extensive mental health needs whose goal for discharge is to stabilize enough to be transferred to long term care. And Rashida, a young African-American woman from West Africa[42] who

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[39] See: Fitchett, "Making Our Cases," 3-18; George Fitchett, "Introduction;" David B. McCurdy and George Fitchett, "Ethical Issues in Case Study Publication: 'Making Our Case(s)' Ethically," *Journal of Health Care Chaplaincy* 17, no. 1-2 (April 2011): 55–74, https://doi.org/10.1080/08854726.2011.559855; David B. McCurdy, "Ethical Issues in Case Study Publication," in *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy*, George Fitchett and Steve Nolan, eds. (London: Jessica Kingsley Publishers, 2015), 282-298; Steve Nolan, "Introduction: Autoethnography in Chaplain Case Study Research," in *Case Studies in Spiritual Care: Healthcare Chaplaincy Assessments, Interventions, and Outcomes*, George Fitchett and Steve Nolan, eds. (London: Jessica Kingsley Publishers, 2018), 11-32; George Fitchett and Steve Nolan, "Editorial," in "Chaplain Case Study Research," George Fitchett and Steve Nolan, eds., special issue, *Health and Social Care Chaplaincy* 5, no. 2 (2017): 167-173.

[40] Nolan, "Introduction," 16.

[41] For more on Case Study Research see: Robert E. Stake, *The Art of Case Study Research* (California: Sage Publications, Inc., 1995); Robert K. Yin, *Case Study Research and Applications: Design and Methods*, 6th ed. (California: Sage Publications, Inc., 2018).

[42] Specific Country removed for confidentiality.

explores the role of her Muslim faith in her illness narrative but struggles to integrate her beliefs into her practice of self-care and overall wellbeing.[43]

These three cases were selected to represent the standard practice of my work while also highlighting the uniqueness of PBHSC. These cases will emphasis the value of chaplain-patient rapport, a heightened state of observation in behavioral health settings, and an emphasis upon patient integration of their self with the goals of care. While these three concepts may not be unique to behavioral health care, I believe that the foci of these cases and the methodologies utilized highlight the overall uniqueness of spiritual care practice in behavioral health settings.

The content of each case is unique in approach in that he three cases together exemplify the coherence of pediatric spiritual care (the focus of the care) and the contingency within practice (uniqueness of each case). Themes within these cases include:

- Agency/Identity
- Spiritual development
- Spiritual health as mindfulness (i.e. "paying attention")
- Individuation
- Ongoing mental health dynamics
- Interdisciplinary consultation

The position I hold was created to provide continuity of care; a practice of following patients from inpatient to residential and/or outpatient programs. I often follow patients for about six plus months when they move through the programs successfully. However, my goal for this project is to highlight the dynamics involved in brief stabilization care.[44] I want to highlight a question which I do not have a clear answer to. What does spiritual health look like when

[43] All patient names are pseudonyms to protect patient confidentiality. Some of the details of each patient have also been altered.

[44] A stabilization unit is for patients who need 24-hour observation while they receive treatment from an interdisciplinary team to reduce the acuity of their symptoms to a point where they can be referred to further care or return home.

partnered with a patient's stabilization goals? In other words, what does spiritual health stabilization look like and how does spiritual care address a de-stabilized spirituality? Again, this is a question I do not have the answer to but one that has informed my approach to spiritual care on these units since I began this practice. I will keep coming back to this concept throughout the case study presentations and analysis.

Chapter 3: A Collection of Case Studies

Michael's Case

Michael is a 17-year-old, African-American, cisgender, male with a past psychiatric history of fetal alcohol spectrum disorder, mild intellectual disability, cannabis use disorder, attention-deficit-hyperactive-disorder, and depression. Michael was admitted to the unit due to suicidal ideation and a desire to assess whether he was having increased anxiety symptoms or increased paranoia. Michael is adopted and lives with two older siblings, a brother and a sister, in the Twins Cities metro area. Michael asked to be brought to the hospital as he was aware of his increasing symptoms and wanted help. From my experience on the unit it is less common for a patient to seek support and/or to openly recognize that they need support. Upon admission he described a sense of hopelessness and worthlessness, as well as moments of difficulty controlling his anger. A significant social difficulty was caused by a former bully with alleged gang affiliations who once told Michael via a social media platform to kill himself. Michael's symptoms of anxiety center around this individual and whether Michael is safe in his social contexts.

Michael is a senior in high school, plays on the varsity football team, attends an Assisted Learning Center, and has been struggling in school. Prior to his admission he experienced decreased focus in classes, challenges feeling accepted and important on the football team, and some recurrent bullying and cyber bullying. Michael worries about encountering gang violence as those who cyber bully him are allegedly affiliated with a gang. Throughout a significant part of his hospitalization Michael remained fixed upon his fear of returning home and potentially facing violence. His persistent fear caused the staff to ponder whether his fear was based in reality or intensified by symptoms of paranoia.

Michael's goals for his time on the unit were to improve his mood and gain more coping skills for dealing with both anger and depression. He did not have any self-identified goals regarding substance use as he did not see smoking weed as a problem. Instead he claimed that he used infrequently and that his use helps improve his mood when nothing else seems to work. While respecting Michael's perspective, the unit attempts to highlight any relational or personal consequences that substance use has in order to encourage patients towards sobriety. Since Minnesota has not legalized recreational use of marijuana and the patients are under 18, there are also legal consequences that can occur when a patient gets caught using. However, in the context of healing and recovery, relapses are symptoms of addiction and youth can be court ordered to treatment rather than charged for possession and sentenced to time in a juvenile detention center.

First Encounter

I first met Michael on the second day of his admission. It was the start of the unit's study time where patients are expected to work on therapy assignments in the lounge for 30 minutes. After study is a snack break (essentially free time in the lounge) after which they go to their rooms for a quiet hour. For me, these two hours can be a good time to build rapport with patients, helping with study, chatting with patients, and/or joining in a game. This has proved a great opportunity for assessing needs, receiving direct requests for support from patients, and simply being seen as part of the staff by the patients. Without building rapport with patients, I sometimes have difficulty facilitating my weekly group and initiating individual sessions. In fact, it was due to spending time in the lounge that Michael and I first began our encounters for this

hospitalization as he had not requested to see a chaplain himself. [45] Further, as Chapman and Grossoehme explain, a patient is more willing to request spiritual care support if they have a better understanding of who the chaplain is and what spiritual health entails.[46] This has proved to be accurate in my practice as well.

I was visiting with two staff members, a psych associate and a nurse, at the edge of the patient lounge after realizing that the patient I was attempting to follow up with was already occupied. As each team member was responding to other patients Michael requested help with a therapeutic worksheet. I explained that I could try and help but may not be the most helpful. It is often the role of the nurse or therapist to work through the worksheets with patients, so I attempted to provide support while staying within the scope of my practice.

Michael's worksheet was titled "Depression and Chemical Dependency." He pointed at a question that asked about the effects that substance use has on depression. This question is written vaguely on purpose to get patients to reflect upon any connections between their substance use and their mental illness. However, these questions can be difficult for a few reasons. First, when a patient sees no connection between use and mental health, they don't understand the value of the question. Second, individuals with learning disabilities can have difficulty with vague questions. I offered an example of mental health challenges leading to increased urges. I started to offer a second example explaining that coming out of a high can lead to feelings of depression or pain but while I was speaking, he wrote the answer "I get high"

[45] It is the hospital's standard practice for the nurse performing the intake to use a simplified version of the spiritual assessment FICA, created by Christina M. Puchalski in 1996. For more information on FICA see: "FICA Spiritual History Tool," School of Medicine and Health Sciences, accessed December 2, 2018, https://smhs.gwu.edu/gwish/clinical/fica.

[46] Chapman and Grossoehme, "Adolescent Patient."

under the question. I glanced at his other answers and realized he had written "I get high" under at least four other questions. Recognizing what seemed to be a lack of insight between his use and his mental health struggles, as well as my respect for his confidentiality, I decided not to engage in further reframing in front of the other patients in the lounge. Instead, I decided to trust that one of the unit therapists would work with him regarding his answers.

Shortly after helping Michael, he asked me, "Do you remember me?" I admitted that he appeared familiar, but I did not remember him immediately. He explained that he was on the unit three years prior and that he returned because "things have been difficult lately." We spoke about how a lot can change in three years including life difficulties, mental health challenges, and appearance. I did not pursue a deeper conversation at this time as I had not reviewed his chart and without awareness of why he was on the unit I could potentially be unhelpful. Normally a question such as, "What has been happening recently that has been difficult?" might be supportive but I decided to wait to do further assessment after consulting with staff and performing a chart review. I ended the visit by validating his choice to come to the unit and I told him that I would see him on Friday during my group.

Second Encounter

I did a brief chart review for each patient prior to my 10am spirituality group on Friday morning. While reviewing Michael's I noticed a progress note written Thursday night by one of the evening therapists which explained that he had a difficult shift. He struggled to focus on the unit programming and to stay in groups because of some of his social stressors. The therapist wrote:

> "Pt reports thinking about peers outside of hospitalization who have threatened to kill him…Pt is very vulnerable to others taking advantage of him—such as gang members. Pt

> has been associated with ___[47] though agrees that joining is not something that he wants to do. Pt also reports being sad as he has been thinking about how his bio mom could give him up and not keep him and try to keep clean. Pt reports understanding around his bio mom's inability to care for him. Struggles not having a father figure as well. Pt does a great job reaching out for support when he needs it and is able to process with staff."

This chart review provided me with necessary information concerning his complex social and family situation and current stressors. I was able, therefore, to enter group knowing that he had a difficult time staying in groups. This knowledge, as well as other patient chart notes, helped formulate the group topic, my body language and tone in group, and my attentiveness towards those with higher acuity.

Michael was the first to arrive to group. I greeted him at the door to the group room and we had a brief talk about his day, his desire to focus on himself, and some anxiety he had following a recent meeting in which he learned that he will leave on Monday. When other patients arrive, I gave him an affirming nod as if to say I hear you. He nodded back, and we moved on to the group process.[48]

There were eight out of eleven patients in my group. It's a circular room with chairs along the walls. The room was lit only by the cloudy sunlight coming through the windows. I sat by the door (in case I needed to get staff's assistance) and Michael sat furthest from the door by the windows which overlook a courtyard. The group started with a brief check in, during which

[47] Name of the gang removed for confidentiality.

[48] There is a lot more that could be said about the value of non-verbal interactions in spiritual care. Carrie Doehring explores non-verbal interactions in a chapter on "Embodied Listening." The awareness of how I use a look, hand gesture, what posture I sit with, or any other nonverbals to communicate things related to patient safety. While it would be beneficial to write about the benefit of non-verbal interactions in pediatric behavioral health spiritual care that is not the focus of this paper. For more see: Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach*, 2nd ed. (Kentucky: Westminster John Knox Press, 2015), 53-72.

Michael mentioned that he was feeling worried. Most of the other patients checked in feeling mildly anxious or just "going with the flow". One patient, who was actively psychotic, checked in with feelings of deep depression. The group was on "Mindful Choices" in which I use *Would You Rather* questions to encourage patients to practice checking in with their current needs and to think about what they can get out of their time on the unit. We processed three questions before transitioning to my default spirituality group topic, "Discerning Your Spirituality."[49]

Michael was on and off engaged in the group process, offering some very thoughtful answers. However, at one point he responded to a prompt with "I'm sorry, it's not your group but I'm just really worried right now. Not about this or here but stuff out there (motioning at the windows). I'm just worried. What was [the question]? Never mind I just need to stay focused on me." I responded with "Ok, that sounds good to me. You let me know if you need anything or need to take a break but continue to focus on your needs and be willing to come back to this room as much as you are able as you continue to focus on the present moment."

Inviting him to "come back to the room" was a way of using coded language. Some patients, including Michael, who have worked with trauma, anxiety, or any other disorders that have the ability to alter perceptions of reality would understand. I was inviting him to use his skills to be grounded in the group room and I was reminding him that he was safe. I hoped this would help remind him that those worries, stressors, memories, etc. cannot get to him now but reaffirm that he is safe. This was the easiest way I could do this in the group process without turning the group's attention to what Michael was experiencing. Michael looked at me for the first time in a while and nodded in an affirming way that told me he heard me.

[49] See Appendix C for a brief description of the "Would You Rather" group process and a "Discerning Your Spirituality" worksheet that I developed for my units.

Third Encounter

Immediately following the group process Michael and I had an impromptu individual session. This is a common practice of mine following a group when I assess a patient may have further needs that could be addressed in a spiritual care visit. I felt confident that Michael would benefit from additional support having reviewed his chart, consulted with staff, and listened to his present difficulties within the group process. Michael spoke to me about the gang he is affiliated with and how he is tired of being associated with them and fears the consequences of his connections. This leads to him telling a brief story:

> **Michael**: Yeah, I saw a kid flashing gang signs and I told him, "come over here." I did, I said, "come over here." And he walked across the street and I said, "don't flash those signs that's not cool. Reading books is cool, learning is cool, being safe is cool. Not that!" So, I changed his life, I helped him, and I have that.
>
> **Chaplain**: Yeah, that sounds really powerful. Is it nice to know that you helped someone?
>
> **Michael**: Yeah, it helps.
>
> **Chaplain**: So, I am curious, what else brings you peace? When you imagine this worry, the connections you have, and trying to get out. What brings you a sense of peace?
>
> **Michael**: Eating right, making music, taking care of my hygiene and my needs, talking about things…um….
>
> **Chaplain**: What is it about making music?

Michael: Oh, I rap. I rap to get things out. Rap gets my anger out. (His demeanor brightens as he shares about rapping)

Chaplain: Great, so it is how you express some things then?

Michael: Yeah, rap works out my anger. It is how I present who I am. I love it. I tried other music. I tried to like country or pop but it's just not for me. I even tried just singing. But Rap is what works for me. Rap gets it out.

Chaplain: Yeah, that's perfect. So, are there any rappers who inspire you? I mean I think about your worry returning home and your desire to get out. Are there any who can inspire you as you do that?

Michael: Well no. None of them are inspiring they all talk about drugs, bitches, and violence. And I don't want to be a part of that. I mean, I talk about drugs, bitches, and violence too but I also rap about my past and my present and how I am trying to be or the things I am learning.

Chaplain: So that's actually what I was thinking about myself. I can't think of any names right now but I know there are some rappers who speak about changing themselves for the better. Who talk about their past and how that has informed or shaped their present or how they just needed to break away. Are there any who do that for you? Any who inspire you by the way that they talked about their past?

Michael starts to talk about a new album, K.O.D. by J. Cole, that has inspired him. He goes on to explain that J. Cole's new album presents a story about deep involvement with drugs and violence as a vice on life. Michael quickly relates the album to his own journey stating that he brought himself to the hospital as a way of getting help with his inner self and his social

difficulties. We continue to talk about this album and the meaning he finds in it. Holding all that we talked about and the value he finds in writing his raps I walked him to his room and recommended that he attempt to write about his anxieties as a way of processing them. He agreed that may be helpful and we ended our visit.

It was my hope in this visit and following that Michael would spend some time with his writing to process his fear of returning home. I informed the staff of our visit and some specifics regarding his use of music as a coping skill, a form of self-expression, and a way of understanding how he feels. When I returned to my office, I began to listen to J. Cole's new album, I read some of the lyrics, and looked up other artists who I thought may be supportive to Michael.

Final Encounter

On Sunday I went to the unit to follow up with Michael. I brought up J. Cole sharing that I had listened to a handful of his songs. Michael and I began processing meaning he found in some of the songs and why he found them so meaningful. He started to compare J. Cole to Kendrick Lamar and others, highlighting inspirational aspects of their music in the ways in which each relate, in similar and different ways, to his own social context and challenges. He talked about family dynamics, social dynamics, mental health problems, and substance use. Michael was able to process through his present context using the lyrics and rhythms of these rappers as a central focus of how he finds meaning. Michael and I were able to utilize tracks from the K.O.D. album and other artist's work to process his sense of meaning, individuation, and even his reflection of beneficial coping skills.

The discussion of rap as a form of meaning-making led us to cover several topics. We processed his life as a young black man, his attempts to act a certain way to avoid the attention of

the cops, and his fear of turning 18 and being seen and treated like an adult. He says "I'm sorry for my language but I'm just tired of the shit. Going in and out of the hospital. Having friends go to jail as if they are proud of it." He spoke briefly about the complications of wanting to heal and be sober when his environment and social contexts continue to provide limitations. Michael added the difficulty of certain friends and neighbors who had committed crime solely to get a roof over their head within the prison system.

We finished our encounter with a reflection on his support systems in which he spoke highly of his mother and his school. He also, for the first time, brought up a desire to try out church since his Muslim mother "always" talks about the benefit of church. We reflected on his mother's religion, his own curiosities regarding religion, and I encouraged him to enter an open conversation with his mother to see what he could learn from her religious practices. After that, I encouraged him to keep writing, finding support from those he trusts, and seeking additional help whenever needed.

Assessment

I am influenced by a few different spiritual assessment models that have informed a model that I developed and utilize with my patients. The assessment model is made up of three primary questions that are influenced by Puchalski's consensus definition and the answers to these three questions can guide a spiritual care towards a patient's potential area(s) of growth. The questions are: 1) What brings you peace? (i.e. coping skills, spiritual practices/rituals, etc.) 2) When/where do you feel most connected to who you are? (sacred/valuable places, reflections on connection/integration, identity development, etc.) And 3) What, if anything, motivates you to be the best version of yourself? (i.e. higher power, family, self, god, etc.) I will refer to these

questions throughout my assessment of each case study and will return to them again in the discussion in chapter four.

In the visit with Michael we focused primarily upon what practice brings him a sense of peace. We reflected on the influence of rap and different rappers who could both influence his lifestyle and his writing. It became clear that writing and rapping also help him to feel connected to himself but that his current practice of rapping "about drugs, bitches, and violence" had made him feel like someone else. I believe that stabilization of Michael's spiritual health included taking a practice which has significant value for how he makes meaning and expresses himself and reshaping this practice from something that he used to represent a gang to something that can help him identify and express who he wants to be. Therefore, this reflection had the potential to support his practice of rapping and writing as a form of finding himself in the midst of his mental health challenges and the social stressors that surround him. While also finding indirect support and inspiration from other rappers who he feels a connection with. Michael's stabilization was focused upon his connection to meaningful activities and his personal reflection and discernment.

The significance of writing and listening to rap for Michael can be understood as a practice that allows him to express where he has been, who he is now, and who he wants to be. In our final visit he shared that *Window Pain* is the song on J. Cole's new album that impacts him the most. *Window Pain* works through the difficulties of a person's wants and situations, with who they are trying to be. It references family, god, anger, hope, and new opportunities. It speaks about the mind wanting to kill, use more, take advantage of women, losing family to violence, and more. After holding the tension between past desires and hope for a new life the

song ends with the words, "Choose Wisely".[50] I reflected on this song as I considered all of my visits with Michael. I believe that Michael's back and forth desires for healing and recovery mixed with the challenges that await him in his social situations are well represented (though not the same) in the song. For Michael, *Window Pain* is his source of meaning, J. Cole telling a story through the tracks of K.O.D. are his inspiration, and his desire to tell his own story and find his own voice is his motivation. While our conversations did not specifically use terms that are specific to spirituality, we were reflecting thoroughly on his sense of purpose and meaning throughout our visits.

Interventions

I focused upon his self-understanding and ability to "self-soothe."[51] Once he identified rap as his form of self-expression, "It helps me get things out," I decided to focus on how that practice not only supported his practice of self-care but also brought him a sense of meaning. I researched K.O.D and listened to different rappers and tracks to attempt to find language with which to facilitate this connection of meaning for Michael. This review is similar to the way I would create a handout of scripture or look into religious scripture or rituals for a patient focused upon religious forms of meaning.

Additional opportunities for deepening our spiritual care relationship include further reflection on his realization that helping others was meaningful to him, including the moment he

[50] J. Cole, "Window Pain (Outro) Lyrics," Genius, accessed December 2, 2018, https://genius.com/J-cole-window-pain-outro-lyrics.

[51] Self-Soothe is not only a self-care strategy but a defined coping skill within Dialectical Behavioral Therapies, the primary methodology of the units I work on. See: Marsha M. Linehan, *DBT Skills Training Manual*, 2nd ed. (New York: The Guildford Press, 2015), 442-445; Jill H. Rathus and Alec L. Miller, *DBT Skills Manuel for Adolescents* (New York: The Guildford Press, 2015), 135-137.

described speaking to the younger kid on the street flashing gang. I think that we could have focused on this more directly, highlighting for him the significance that influencing others in a positive way has on his personal set of values. On a systematic level I believe that there could have been an opportunity to work with the interdisciplinary team to facilitate a connection with a organization that supports youth who are seeking alternatives to gangs.

Outcomes

Michael was able to reflect upon rap as his primary form of expression and think critically about how he can shift from rapping as an affiliate for a gang and instead rap about his sense of self. I experienced Michael gaining a sense of hope as we spoke about inspirational rappers and he saw that he too could utilize rap to tell the story he wants to live. This, therefore, not only provided an opportunity to strengthen a central coping skill but helped Michael to see rap as a connection to his sense of motivation and hope. Through our reflections of meaningful rappers, he was able to articulate what motivation, purpose, and understanding he found and how that connected to his own personal experiences and beliefs. Michael also began to share his rap with staff and peers on the unit. He shared confidently brief vignettes of his story, primarily focusing on his hopes for the future, support from his mother, his belief in a god, and his desire to get to a better state of mind.

If I had the opportunity to continue working with Michael, I would continue to encourage his writing, I would inquire more about his personal and familial spiritualities, and his understanding of who he wants to be as communicated through his lyrics. However, for his brief stay on the stabilization unit I believe that a reflection on the intentionality he puts into his writing and the meaning he finds from other rappers benefited his overall stabilization and his ability to manage his mental health struggles.

Rashida's Case

Rashida is a 17-year-old, African-American, cisgender, female from West Africa. She has a past psychiatric history of major depression, post-traumatic stress disorder, and attention deficit hyperactive disorder. She came to the unit voluntarily following some "out of control feelings" and suicidal ideation. She has a substance use history, but substance use is not a present concern. While Rashida presented with various difficulties, she had a self-identified goal of getting her medication in balance and discharging within three days. Rashida's case is unique to the other two because our encounters span two different hospitalizations. She came to the unit twice in a period of three months. The first time she was admitted following a suicide attempt.

Rashida has a younger brother who she is very close to, but he has moved back to West Africa. He is the same age now that she was when she first experienced physical and sexual abuse from a family member. The psychiatrist believes that the separation from her brother as well as the compounded factor that he is the same age as when she experienced trauma, may be contributing to her experience of increased flashbacks and nightmares. She has had four suicide attempts, the most recent being the reason for her previous hospitalization. Her parents also have mental health illnesses and they are interested in finding her integrative methodologies for healing, including yoga, reiki, mindfulness practices, CBD oil, and more. She currently lives with her mother, 3 sisters, and 1 brother. The rest of her siblings and her father are in West Africa. She hopes to return to West Africa permanently with her whole family in the near future.

Prior Hospitalization

Rashida and I first met when I responded to a request for a Quran. I brought the Quran to the unit and did a brief assessment of the benefit a Quran would bring to her hospitalization. This is a standard protocol for our chaplains on mental health units as some patients have been known

to fixate on the content of a sacred text in a way that is unhelpful to their hospitalization. In these situations, and with the patients, we assess what will be helpful for their present needs and what may not be helpful. Rashida openly shared that she does not find reading the Quran helpful but that having it close to her is something she finds supportive. She then added that what she really wanted was someone who could read the Quran to her in Arabic because she finds listening to the Quran being read or sung very soothing. This was something we attempted to set up for her but due to the limitations of our Imam Chaplain's schedule and the brevity of her hospitalization, we were unable to set this up.

During our visit, Rashida and I spoke about her Muslim faith, focusing primarily upon the aspects she found significantly meaningful. We also focused our time on grief education and reflection. A primary stressor for Rashida's prior hospitalization was the depressive symptoms that had developed due to her younger brother moving back to West Africa. We spoke about the complexity of her grief, she shared stories about her time with her brother, and we spoke about some coping strategies to support her wellbeing. The main outcome for this visit was for my consultation with our Imam Chaplain who attempted to see her but was unable to follow up. Rashida was hospitalized on a Wednesday, I saw her on a Friday, and she discharged on Monday afternoon before I could follow up with her.

Second Hospitalization: First Encounter

Three months later, I noticed that Rashida had returned to the unit and had asked to see a spiritual advisor. I was first able to see her during my spirituality group. During my chart review I noticed that there were not many notes in her chart because she had skipped groups in order to sleep the day prior. Therefore, I did not have a lot of information regarding what had happened

in the past few months. I assumed that she had continued difficulties with being separated from her brother and was experiencing heightened symptoms of post-traumatic stress disorder.

I was curious whether her request would be similar to her first hospitalization and whether she would want me to contact our Imam Chaplain. I did not initiate this request however because I was aware that a lot could have changed since our first encounter and that she may not have the same request. Her chart noted that she admitted herself to the unit and that stated a willingness and desire to get what she could out of the unit. However, she had slept through all attempted groups and medical assessments thus far.

The group that morning was challenging. It was on the topic "Discerning Your Spirituality." There were nine patients in the group and only four of them remained consistently in the group for the whole hour. Rashida was one of the patients who stayed throughout group. She remained engaged throughout the group process, visibly annoyed at other patients who were not taking things seriously, and she showed signs of managing her irritability throughout group. She also shared deep insight throughout the group. In response to the question, "What brings you peace?" she stated, "smoking weed" and went on to share how she knows that it is an unhealthy response but wanted to be honest and start to reimagine healthier responses. She continued to share insightful comments throughout group that honored her difficulties realistically but also reflected upon what else could be.

About thirty minutes after the group process, I pulled Rashida from exercise group to have an individual session. We talked about her ability to cope with her irritation during group and I validated her ability to focus on her own needs. Below is a portion of our conversation:

Rashida: You know, I brought myself here.

Chaplain: Good for you, it takes a lot to do that. So, what was it, if I can ask, that caused you to do so?

Rashida: I was feeling suicidal. I wasn't suicidal, I didn't want to kill myself. But I was feeling suicidal. Does that make sense?

Chaplain: Yes, it does. And it is actually a great way of saying it to highlight the symptoms you were experiencing.

Rashida: Yeah, I was talking to my therapist and she asked me to describe how suicidal I felt on a scale of 1-10. I was at a 9 and she recommended I get help, so I came in.

Chaplain: Great, so what are you working on or hoping to get from this time around?

Rashida: I need to get my mind in order, get some things figured out because my anger and anxiety have been a lot lately.

We go on to talk about some social dynamics from school and family dynamics. She stated, "I try to sit down and meditate and then I get called downstairs; 'Rashida can you cook dinner, I need a break!! Can you do the dishes? Rashida, I need a back massage!' I just don't get to take care of myself sometimes." We spoke about the challenge of not having adequate space for herself at home and reflected on some ways that she can practice staying grounded.

Chaplain: So what things help you do that? What grounds you?

Rashida: My sage, my crystals, my baby brother.

Chaplain: Of course, I remember talking about him, he is in [West Africa] though right?

Rashida: Yeah, but I keep a picture of him on me now.

Chaplain: Oh, can I see it?

Rashida: Yeah, he just brings me so much peace. He slept with me when he was a kid. He slept with my mom for two nights but then I was like, he is going to sleep with me. And I just took care of him. I would wake up at 4am and feed him. He called me mom for a bit. My mom didn't like that. But I just love him so much. Sometimes this picture is helpful. Sometimes it makes me angry remembering how much I miss him.

Chaplain: Yeah, being grounded is sometimes like finding a balance. Just like you are doing here with your mental health.

Rashida: Yeah, finding a balance. Like at school, I'm suspended now, ugh it is a racist school. But I got angry and I would usually fight someone, and I had this security guard following me, but I didn't fight anybody. Instead I threw a chair.

Chaplain: Well that might not be the balance I was talking about.

Rashida: No, like the guy told me that I could go in a room and he would let me do whatever to get it out. I threw a chair and he just checked on me and let me keep going.

Chaplain: Oh ok, yeah that's part of it then I guess. You didn't hit someone. Instead you found a chair you could throw. And someday you won't need to throw chairs but will find another, potentially less destructive, way to let your anger and anxiety breath.

Rashida: Yeah, nature does that. Last time I was here I got so angry cause I couldn't go outside but then after a week and a half I went outside and the sun on my skin. Oh, it felt so good.

Chaplain: Well and that feeling can take us to a different place sometimes can't it?

Rashida: Yeah, it helps grounds me, brings me back if you know what I mean.

Chaplain: I think I might. I have a few places I have hiked that when I am stressed, I can close my eyes and try to imagine every detail of my favorite lookouts. Sometimes it feels like I am there. But even just imagining it can relax me. I'm sure you can think of some places too.

Rashida: Yes! Oh, the mountains in [West Africa] the goldish rocks (pause) yeah, I can imagine that.

Chaplain: And don't get me wrong it is not the same as being there but that kind of self-guided imagery can be really supportive on difficult days. Or even cold days like this one.

Rashida: Yeah, that's true. I really like that idea.

Our conversation centered on the topic of balance. We discussed finding a balance with her anger, utilizing her mindfulness to thoughtfully keep herself from doing things that would get her in trouble but still finding ways to get her anger out. We also spoke about finding a balance in relationships with her mother, a young man she is friends with but is also starting to date, and with her Muslim faith. We continued to talk about how she finds a balance in her relationship with her mother. Rashida identified that she is "not as Muslim" as her mom and that they have come to terms with each other and the way they practice their mutual faith in different ways.

For example, she explained that she does not wear a hijab, but still loves the sound of the Quran being read or sung but she also finds support and peace through crystals, burning sage, and receiving reiki. I offered to bring some sage, sweet grass, and cedar essential oils in a cotton

ball so that she can have the scent with her, and she agreed that would be supportive to her needs.

While Rashida showed deep insight into her present illness narrative, we were able to work significantly upon her continued need for balance, letting her emotions breath in healthy ways, and different practices (religious and not) that help her ground herself. She had a goal of discharging by Sunday but that was unlikely. On this visit she said, “I want to be here but if they try to keep me here I will lose my balls.”

Final Encounter

On Monday Rashida was still on the unit. I decided that I would follow up with her to provide any follow up support. She was in a group at the time of my attempt and three patients were arguing when I pulled her from group. “Just in time,” she said as we greeted one another. Rashida was carrying a journal with her and when I asked, “How is today going?” she immediately began to tell me about a plan she had made for her discharge and that she was going to be working on the plan up until her discharge meeting. She began to read a plan that was all about getting back to her “religious roots.” She continued to explain to me that as long as she follows her mother’s leadership and instruction, she will be okay and she will be able to find support from her religion like she used to do. This seemed like a sudden shift from our discussion of balance and her own meaning of her Muslim faith and it made me wonder if she was seeking to please her mother in order to rush her discharge.

Rashida had a different tone in her voice and a different posture about her. While these can be good signs it also seemed as though she was trying to convince me on something. I began to wonder if she was saying what she thought I wanted to hear. However, I did not want to challenge or doubt her so instead I began to assess the value she found in her religion.

Chaplain: So, what is it about your religion that brings you support?

Rashida: It is the prayers. Although I just pray when I feel like it. And it is parts of the Quran even though some parts are really violent…

Chaplain: Yeah, some parts of the Bible are too, actually parts of many sacred texts can be.

Rashida: Yeah, and it is god. God is supportive to me.

Chaplain: What about your belief in a god brings you a sense of support?

Rashida: Oh, it is just everything that god is. God is peaceful and caring and his presence. I just find so much support knowing that.

Chaplain: It can be very comforting to believe that there is a creator who provides that peaceful and caring presence.

Rashida: Yes, and I know that if I just do whatever my mom says and if I give my mom full leadership than I will be better off.

Chaplain: Wow, this is a lot. And I love it. But I believe this is all coming from someone who told me they would "lose their balls" if they didn't discharge by Sunday.

Rashida: (laughing) Yes, I just decided that this place is really nice. It is a break and it is a place to work on myself. So, I would like to leave today but if I can't that is ok.

Chaplain: That's wonderful. And I know that last time we met you talked about the challenging pressures from your mom but now you are saying you want to completely follow your mom's leadership. Is that true?

Rashida: Well, I have just been considering getting back into my religion and I know I need to just do whatever my mom says.

Chaplain: That could be true, of course. However, I would also like to recommend that you continue seeking a balance in all of it. You know? Learn from your mother when and where that is helpful but keep listening to your needs and the areas that you find supportive as well. Does that make sense?

Rashida: Yeah, yeah, I of course need balance as well. (looks at her notebook and then back at me) so yeah, I am hopeful to discharge today but if I can't I can keep working on myself.

Chaplain: Of course, you can! And you have been doing a lot of great work too!

Our conversation wrapped up shortly thereafter at which point I went to check in with the therapist she had been working with. He explained that there had been some inconsistencies with her reported mood, plans, and goals throughout the past three days and that the unit staff believed she was starting to "play the staff" in order to rush her discharge date. In moments like these, staff, including myself, can only work to encourage a patient's integration of their values and goals of care with their present illnesses but we cannot force individuals to be mindful about their individual needs. The therapist and I also discussed the patient's complex relationship with her mother and some ongoing concerns the staff had. He then informed me that Rashida had requested a prayer rug and hijab. I explained that I would bring some resources for her after her family meeting if she was still hospitalized but also let him know that she mentioned none of

these requests to me in our visit, potentially highlighting more inconsistencies.[52] Less than two hours after my visit with Rashida she was discharged home and recommended follow up care in a day treatment setting.

Assessment

In my work with Rashida I focused our reflection on balance and supportive theologies trying to discern with Rashida beliefs and practices that help her feel a sense of peace and connection. While I did not ask my three primary assessment questions directly, I did consider them as a framework for our reflective conversations. Assessing my work with Rashida, I think of Carrie Doehring's "embodied lived theologies" which explore a conceptual approach to an internal understanding of an individual's spirituality. Doehring writes, "caregivers can listen for the embodied emotional/spiritual logic that connects a set of core values, foundational beliefs, and practices for coping with stress and connecting with god/the goodness of life."[53] The concept of embodied lived theologies makes room for exploring theologies that individuals have been born into, raised with, and the theologies that individuals gather throughout their lived experiences and their developmental stages. With Rashida, I considered the meaning-making she expressed between her Mother's practice of her Muslim faith and Rashida's own attempts to discern what aspects of Islam were supportive to her wellbeing. This is also where I became concerned when Rashida stopped thinking about her individual practice and said she needed to just do exactly what her mother would like. While I encourage patients to find inspiration and

[52] Family meetings with a licensed family therapist are a standard practice of this unit. The meetings occur early in the hospitalization, and again at the end of the hospitalization for discharge planning.

[53] Doehring, *Practice of Pastoral Care,* 4.

connection with their parents it felt as though Rashida's individuality was being left out of our final reflection.

Doehring also introduces life-giving and life-limiting theologies which consider different embodied theologies that may contribute to an individual's wellbeing or may contribute to their sense of shame based or stress inducing theologies.[54] My final encounter with Rashida attempted to co-reflect with Rashida any aspects of her goals that would support life-giving theologies or contribute to life-limiting theologies. I think that processing the complexities of an individual's theology can be a difficult process, especially in mental health contexts, but the process of co-reflection is an important step towards an individual's integration of their theology with their coping skills, mental health, and overall wellbeing.

Overall, it appeared to me that Rashida, and her mother, have significant resources for spirituality and their overall self-care. The challenge they each face is in the negotiation of each other's spiritualities and Rashida's discovery of self.

Interventions

The interventions in this case would have been rather simple and quick in another setting. A request for a Quran, prayer rug, etc. would have had a swift response from a chaplain delivering the materials. However, this case highlights one of the unique competencies of pediatric behavioral health care. I triaged the effectiveness of the resources before offering or providing them, assessing whether or not they would be life-giving or life-limiting to the patient and to the stabilization goals of the unit. As a spiritual care provider, I value and support a patient's religious freedom, but this type of assessment of the benefit of resources can support an

[54] Doehring, *Practice of Pastoral Care*,12-13.

individual's healing process and provide them with specific resources for their healing. It can also prevent a chaplain from providing resources that may contribute to a patient's fixation upon potentially life-limiting theologies or even theologies that might distract from the present healing process. Therefore, assessing the benefits of resources is about assessing the current benefit the resource will have on the patient's stabilization, while also providing them with a connection to spiritual health support.

In our brief time together, Rashida and I worked on the integration of her "embodied lived theologies" with her medical narrative. We reflected on the benefit of her religiosity and co-imagined ways she could continue approaching her practice of self-care. The interventions also included close staff consultation as we assessed whether or not Rashida was pretending to be better to get off of the unit faster.

Outcomes

It is difficult to identify the outcomes of this case. I believe that the care provided allowed Rashida space to reflect on her spirituality and the way that it does (or does not) affect her mental health and overall wellbeing. I believe that the outcomes of our time together can be summarized by what Doehring calls theological reflexivity. In summary, theological reflexivity is the reflection of an individual's understood theologies to discern what elements of meaning and practice are life-giving and what is life-limiting. Such moments provide opportunities to excavate these beliefs, values, and habitual ways of coping and decide whether such embodied theologies are still relevant and meaningful, especially in terms of helping people connect with a sense of the sacred and make sense of what is happening.[55]

[55] Doehring, *Practice of Pastoral Care,* 19.

Rashida and I engaged in reflexivity that served two purposes, 1) we were able to assess the life-giving qualities of her religious narrative and 2) she was able to reflectively imagine the ways in which she created a sense of balance in her life and her overall coping. If I had the opportunity to continue working with her, I would focus more on her connection with herself and the development of her spiritual identity.

Sara's Case

Sara is a 16-year-old, Caucasian, cisgender, female with a history of bipolar type 2, and attention deficit hyperactive disorder. She was brought to the emergency room after attempting to hang herself. During her attempted suicide she fell and hit her head giving her a concussion. This was her third suicide attempt in two years. According to the psychiatrist's chart note, she has chronic suicide ideation and depression. She told the psychiatrist that she no longer cares about her life and that family will just have to deal with it when she is gone. She said that she used to believe that it could get better but within the past two years she had lost hope and says that something within her has changed. She has also experienced some displacement from her home over the past couple of years while her mom was attending treatment programming for her own mental illness challenges. She now lives with her Mom, Stepmom, and their one dog. She also spends a few days a week with her Dad who has several animals.

In the medical notes it seemed as though there was difficulty deciphering between her clinical diagnoses. She talks about wanting more ADHD medication but not being sure if her inability to focus is due to her ADHD or is representative of a manic episode with her bipolar disorder. All throughout her medical chart are quotes about self-esteem and shame: "I don't like myself," "I don't feel like myself," "I always mess everything up." However, her goals for this hospitalization are solely to "get on the right meds." She states that she uses cannabis daily to help with her mood and to feel less suicidal and, when available, she uses oxycodone or xanax. In reviewing her chart, I felt as though she was not connecting her low self-esteem with her mental health dynamics. She would talk about waiting until the unit got her medications *right,* but she would not talk about any personal agency or areas of growth to support her healing.

She experienced physical and emotional abuse from her mother when she was younger, as a result of her mother's ongoing mental health needs.[56] She also experienced sexual assault from an older female friend. Sara has been to five different treatment centers, moving through some of them quickly while others she stayed in for months. However, she does not believe that any of these have been helpful since she is still experiencing mental health problems.

First Encounter

I went to the unit during study and snack time to interact with the unit milieu. Though there were eight patients on the unit, only two of them were in the lounge. I started to engage with these two and the staff member who was with them. We talked casually about the day and Sara's job in retail before I offered a magic trick as an ice breaker. They caught my poor sleight of hand during the trick which caused Sara to want to show me a better trick. It was not intentional to have them catch the trick, but it seemed to help our rapport. After the tricks, I introduced myself more fully and explained my role on the unit. The staff member, two patients, and I continued to engage with each other, joking with each other and sharing stories of working in retail. Once it was time for them to transition to their rooms, I let them know I would be back to lead a group in a couple of days.

I knew that Sara could benefit from an individual session, but she had only just arrived to the unit and there were no immediate plans for her discharge. Therefore, I decided to use this

[56] Reportedly mom suffers from cannabis use disorder, bipolar disorder, borderline personality disorder, depression, and anxiety. A patient's hospitalization is sometimes made complicated by their housing situation and what kind of support they are able to go home to. If this becomes a concern the social worker will, at the minimum, connect the patient to continued resources. In situations where the patient's safety may be at risk, child protective services will be contacted.

encounter as rapport building. I made a plan and consulted with staff to follow up with Sara after my group so that we could focus on her self-esteem development.

Second Encounter

While reviewing the chart notes before my spirituality group, I noticed that Sara spent most of the previous day cursing at staff, refusing treatment recommendations, and remaining in her room. One note stated that Sara began to refuse the unit programming and staff support after she heard that she was being recommended to long term residential treatment. When staff asked her why she was refusing unit programming she stated, “Because none of it matters, I’m never leaving anyway.” After reading all of this I assumed she would not be attending my group. However, Sara showed up to the group process and checked in thoughtfully, stating that she had recently learned that she needs to focus on her own ability to change her responses to her emotions. Shortly after checking in she stated that she was getting a bad headache and she was excused from group.

Sara’s headache was a symptom from her concussion and she needed to rest. Her nurse stated that it would still be fine if I attempted to talk to her as light was the main trigger for her headaches. Therefore, I went to Sara’s room to check in and simply let her know that she was missed in the group process. Sara was lying in a dark room with the blinds shut and a pillow over her head. She had a thick quilt over her but she was not allowed sheets in her room due to her risk of suicide. I briefly mentioned that I was sorry to miss her in group and I asked if I could come back later to check in if her headache had improved. She said, “Yeah it is really bad right now, but I would really like that if you could.” I shared this with staff and made a plan to return later in the afternoon. Staff specifically asked that I come during quiet time when there are no groups as they wanted to encourage her to attend groups when her headache improved.

Third Encounter

I returned later that same day during quiet time and I went to Sara's room to check in with her. Sara was under the quilt again with a pillow over her head, the lights were off, and the blinds were shut.

Chaplain: Oh, sorry to find you like this again.

Sara: Yeah, it's ok but I'm not going to group there is no fucking point.

Chaplain: I hear that and have good news for you. There is no group at this time. It is quiet time. So, you are doing exactly what you can/should be doing.

Sara: Oh, well sorry.

Chaplain: No worries. Why do you say there is no point to groups?

Sara: Well because I am going to residential. So, I am just going to lay in here and do nothing until it is time for me to go.

Chaplain: Hmm.

Sara: I will just lay in here and do nothing which is exactly what I will do when I get there.

Chaplain: So, you are committed to doing nothing? Why's that?

Sara: I just don't see a point. None of it will help me.

Chaplain: I hear you but I'm curious why you think nothing will help.

Sara: This is my fifth inpatient stay, [residential treatment] will be my sixth if they were helpful then I wouldn't be in here.

Chaplain: Well, potentially, and I totally hear your frustration…

I decide to give her frustration a break as I don't want to stimulate her symptoms of irritability or her headache. I changed the topic to the many pets she has at her Dad's house. We reflect together on the sense of meaning she feels taking care of them and the peacefulness they bring her. I then transitioned us back to reflecting on her interpretation of treatment programming.

Chaplain: What do you think has been the missing piece? Like the thing that hasn't been addressed? I know it may not be for me to ask but you say these five treatments haven't been helpful and I'm wondering why you think that is? What is missing?

Sara: I don't know they just don't help.

Chaplain: Don't help with what? It is hard to know what they are missing without that detail, you know? And you don't need to answer that to me but maybe with the therapist here you can think about that.

Sara: There is something bad inside me. Something bad that keeps coming back. A bad feeling. I know I'm getting medication to help with it and I think that is all I need but it is just there and it is hard to describe.

Chaplain: Well that's a start and that, that is the *real* difficulty you know. In fact, I think that it is your spiritual health, your ability to know how and/or when you feel connected to who you are, that helps you determine when your mental health is in need of support.

Sara: Yeah.

Chaplain: So, I wonder what it would be like to work with staff to focus on that piece. To try and put more words to it.

Sara: Yeah maybe.

Chaplain: Hmm that's different than a no. I will take it!

Sara: Can I trim my nails?

Chaplain: Umm I'm sure you can but I also don't know.

Sara: Well, I need to be watched doing it.

Chaplain: Ok, well I will get your nurse and have them assist you

(she goes on to tell me about multiple "damn hangnails")

Chaplain: Yeah, I will get your nurse and you can get rid of those annoyances.

Sara: Should I go get him?

Chaplain: No, you relax, its quiet time and shift change it would be better if I did and you could just chill till he is available. Cool?

Sara: Yeah.

Chaplain: Alright, well can I leave you with a little spiel?

Sara: Yeah that's ok.

Chaplain: Ok you may not like it but here we go. Whether you "see a fucking point" to groups or not, don't give up on taking care of yourself (pause). You can stay in here to recover when you need or to tend to your headaches but there is a chance that some of

those groups could help you with that bad feeling inside. There is a chance that some of us may have some good things to offer or some new ways to look at things. But the more you are able to keep paying attention to your needs, your desire for learning, and your difficulties, the greater chance you will have of finding something of value. Or at least more of a chance than laying in here. That just sounds boring.

Sara: (tearing up but also laughing) Yeah, ok I will think about that.

Chaplain: Ok maybe think about it in the next group! Oh, was that too much? Too much too soon? (I make a face and then smile at her)

Sara: (smiles and laughs)

Chaplain: To roughly quote you from group earlier. You get to focus on you, your independence and your needs. Keep taking care of yourself and we can talk some more next week if you are still here.

Sara: Ok that sounds good, thank you.

Chaplain: You are welcome. I will go let your nurse know about those damn hangnails.

After our visit I spoke to her nurse and I planned to follow up with Sara on Monday. Monday would be her 10th day on the unit by which time most of the peers she began her hospitalization with would have been discharged and she would be preparing for long-term treatment.

Final *Attempted* Encounter

On Monday, I first reviewed Sara's chart notes from Friday night and the weekend. Though the effectiveness of our brief visit together cannot be proven, her chart showed that she

began to attend unit programming on Friday evening, and she continued attending throughout the weekend. She still had difficulty with self-esteem and the occasional outburst at staff, but it was significant that she was engaging with the unit methodologies more. After reviewing her chart, I was optimistic that we could have another individual session to focus upon how her spiritual health can help her seek connection between her mental health problems and her understanding of herself. Carmen Schuhmann and Annelieke Damen identify pastoral care as, "representing the good" in which the good can be the ways in which we encourage "others" to seek further connection with themselves.[57] I was hopeful that Sara and I would be able to engage in a conversation that would help her to draw these connections of the goodness within herself.

When I arrived on the unit a Psych Associate informed me that it was a rough start to the day and that Sara "had a teenage tantrum" during group because she couldn't call her Dad when she wanted to. She proceeded to curse out staff during the group process, again in the hallway, and then she slammed her door. Contrary to her previous moments of heightened irritability, she made a point to come back out and apologize to the nurse for the things she said.

I decided to check in with her therapist about whether or not it would be beneficial for me to follow up at this time. The therapist informed me that Sara had been engaging in some staff splitting behaviors and the staff were concerned that this might be symptomatic signs of a developing personality disorder. Therefore, we decided that I would wait till later to check in with her if she was available.

[57] Carmen Schuhmann and Annelieke Damen, "Representing the Good: Pastoral Care in a Secular Age," *Pastoral Psychology* 67, no. 4 (June 2018): 412, https://doi.org/10.1007/s11089-018-0826-0.

Unfortunately, as is often the case in chaplain caseloads, my schedule did not align well with her schedule in the next two days and we were unable to follow up. In reflection, I believe that our sessions were still beneficial as I was able to assist with a period of stabilization (i.e. attending groups) and some interpersonal reflection but was unable to follow up on a deeper spiritual health focus.

Assessment

I began my work with Sara in hopes of discussing her self-esteem. Though we never explicitly discussed her self-esteem we did focus on her level of integration between her sense of agency and her mental health. This work was inspired by developmental theories of spiritual development and its roots with an individual's personal development. Dr. Lisa Miller speaks about spirituality and adolescents in her book, *The Spiritual Child*. She writes, "Awareness of spiritual development creates opportunities…for the important inner work required for individuation, identity development, emotional resilience, character, meaningful work, and healthy relationships."[58] This was my hope for Sara.

As I read Sara's chart notes throughout her hospitalization, I saw a pattern of her just waiting to get her medications adjusted and her not seeing a purpose in her personal engagement. While medications are a primary form of support for a number of individuals suffering from mental health problems, they require the accompaniment of personal reflection and coping mechanisms. The unit I work on utilizes a methodology called Dialectical Behavioral Therapies that develops an individual's mindfulness of their personhood and their mental health

[58] Lisa Miller, *The Spiritual Child: The New Science on Parenting for Health and Lifelong Thriving* (New York: Picador, 2015), 3.

challenges.[59] It is this connection that I believed Sara to be lacking and I hoped to continue working with her on forming this connection. However, in support of her continued stabilization, including not contributing to staff splitting, I was unable to follow up with her further in her hospitalization.

Intervention

Sara and I engaged in a reflective conversation that was meant to challenge her connection to herself and her mental health problems. In the conversation there are moments when I challenged her self-reflection and other moments when I tried to offer breaks by reflecting on her pets or sharing some humor. This was a strategic way of not pushing her too hard or causing further irritation. I also swore with her which I do not see as a necessary practice and in some cases swearing can cause anxiety for patients. However, in the final visit with Sara I used her phrase "there is no fucking point" to hold in contrast that while she may not feel like there is a point to things, if she participates in the unit programming, she may find a connection for her needs. Which, of course, is the point. In our short time together, I attempted to engage her ability to make meaning of the hospitalization for her illness narrative. Together we reframed the hospitalization as a time for her to focus on her needs and think critically about how she wants to focus on her healing and recovery.

Outcome

The most significant outcome in this case was Sara joining the unit programming following our first individual session. I believe that Sara felt heard and was able to reflect on her

[59] Rathus and Miller, *DBT Skills Manual for Adolescents*.

deeper worry of having “something bad inside.” This reflection potentially helped her to experience someone who was able to hear her struggles and see them as something separate from her true self. If Sara was attending the long-term treatment center I work at, we would continue to focus on her spiritual development as a protective factor to her mental health dynamics. However, given her transition to another program I am hopeful that she continues to develop a mindfulness that can support her overall connection to herself and contribute to her spirituality.

Chapter 4: Spirituality as Integration

The cases in the previous chapter were selected because each case highlights a unique aspect of PBHSC and overall the three cases show themes of spiritual care such as meaning-making, connection, and individuation contributing to the patient's healing and stabilization process. In this chapter I expound upon the importance of these themes, articulate how they contribute to an individual's spirituality, and reflect further on the significance of PBHSC. I will first highlight some patterns regarding the patients in these cases. Then I will continue to expound upon themes of the spiritual care practice.

The first pattern is that a significant number of patients I work with do not initially request to see a chaplain. This pattern is also true for these three cases. Michael and Sara did not request to see a chaplain and Rashida requested to see a Spiritual Advisor. Grossoehme, in an article on adolescent patient requests, suggest that patients are more likely to request spiritual care if they know the individual providing care or if the interdisciplinary staff explains what spiritual care is.[60] This is consistent with my experience as well. Patients benefit from understanding the breadth of spiritual care and being introduced to the spiritual care provider. Otherwise, most of my patients will not request spiritual care support. For example, in Sara's case, following some brief interaction and the spirituality group, she said that she "would really like it if [I] could" return for follow up support.

There is a brief intake assessment that the patient's nurse performs during the admission called the FICA screen. This screen was developed by Christina Puchalski and briefly reviews an individual's faith, the importance of their faith, community support, and anything they would

[60] Chapman and Grossoehme, "Adolescent Patient."

like addressed in their care. During the admission the patients are asked if they would like to see a "chaplain, clergy person, spiritual advisor, or no thank you." Beyond the admission questions some of the staff talk about me by name and describe what types of topics I often discuss with a patient (i.e. grief, coping with anger, mindfulness, etc.). One night an evening nurse answered a patient's question regarding what spiritual care was and the next morning I had requests to see over half of the patients on the unit. In my experience, adult BH patients are more likely to request a chaplain and have specific religious, humanist, or spiritual requests that respond to their often more embodied lived theologies.

It is for this reason I value consultation with the clinical staff, building rapport with patients during study/snack, lunch, or other opportune moments, and the work that spirituality groups can do to highlight a patient's needs for continual support. All of these types of informal assessments are highlighted in the case studies and show the work that spending time with patients in an intentional but informal way can produce rapport for continued support. In fact, these informal assessment strategies could be understood as interventions focused on approaching a patient, such as presenting a magic trick or assisting with assignments during study.

As a part of the clinical staff it is recognized that I am continually doing assessments for those who could use support. The staff welcome my visits with any of the patients. In fact, their openness to my visits with any patient has proven to be one of the difficulties in getting the staff to screen patients for spiritual/religious needs. The current medical director of our pediatric psychiatry units emphasizes that, "everyone could use a visit from [a spiritual advisor] and a chaplain's assessment would be stronger than any other staff member." While I agree with the medical director, my role, and the role of my colleagues, falls victim to the problem many

chaplains face: There is not enough time to to screen and prioritize all of the visits needed in an efficient matter.

The second pattern is that many patients I work with do not utilize religious language, rituals, or the like to describe their spiritual health needs. Similarly, two out of three of the cases do not have religion as a central discussion point. In my experience on this unit a majority of patients do not identify with any one religion and/or they do not find religious reflection supportive to their care. There are cases, like Rashida's, in which religious reflection, religious growth, or religious support can be beneficial for the patient's integration of their care. However, most of my patients do not articulate a religion as supportive. Further still, several of my patients are recovering from life-limiting theologies and living with anger, judgements, or sometimes trauma from experiences with religious communities or family members. This demographic has challenged me to think critically about the role of spiritual care within PBHSC settings. I have reflected critically on how to offer spiritual care to the religiously affiliated, those recovering from religious dynamics, and those who are not connected to a religious orientation. Therefore, spiritual care can be informed by religious dynamics but is not dependent on a patient's religious orientation. I provide spiritual care to all patients through a required weekly group and the additional individual assessments upon request reflecting on and articulating the foundations of spiritual health for any individual and what makes up a healthy spirituality.

I found Puchalski's consensus definition an explanation that potentially broadens the understanding of spirituality beyond religious care. For example, with the emphasis of spirituality on an individual's meaning and purpose, as well as their sense of connection, the role of religion becomes just one aspect of their spirituality. Therefore, a reflective conversation surrounding Michael's self-expression and sense of meaning being found in music, or a focused

conversation regarding Sara's integration of her goals with the unit methodology become conversations about their spirituality. In the cases in chapter three religion is both a benefit and a challenge to a patient's own stabilization. Any individual's primary sense of meaning-making during the hospitalization may include religion and it may not. Additionally, I have worked with individuals who claim religious affiliation but when we explore for their sense of meaning, purpose, or connection they struggle to articulate any meaning within the religious orientation. Even still it is important to inquire about an individual's religious or spiritual affiliations. Helen Land suggests that an individual's spirituality is always present in the hospital room, whether a care giver chooses to hear the entirety of the patient's experience can make a difference in patient compliance with their treatment goals.[61]

In summary, religion is not the totality of an individual's spirituality and therefore it cannot be the totality of the spiritual care provider or the primary lens through which a spiritual care visit is assessed. Spiritual care providers tend to the named and unnamed parts of an individual's spirituality, respecting people's narratives instead of making it fit our framework. The foundation of an individual's spirituality is simply their understanding of how the make meaning from their lives, their sense of purpose, and their connection to themselves and all that surrounds them. Again, this definition, an abbreviated form of Puchalski's consensus definition, it is not an exhaustive definition of the particularities of diversities within spirituality but a broad framework in which spiritual health can be approached. Spiritual care is the practice of highlighting areas of connection within the human spirit. The areas of connection that provide someone with felt or articulated understandings of their sense of meaning, purpose, and connections to themselves as well as others. One aspect of spiritual care in PBHSC setting is the

[61] Land, *Spirituality*, 7.

work of integrating a person's self with their medical narrative. I will use the rest of this chapter to highlight the ways that PBHSC tends to the unique needs of these patients, specifically, the challenges within a patient's sense of meaning-making, connection, individuation/agency, and integration.

Spirituality as Meaning-Making

As I have mentioned throughout this paper, by utilizing the consensus definition published by Puchalski, spiritual caregivers must then expand upon its meaning for spiritual care practice. Regarding meaning-making, spiritual caregivers provide contemplative space to reflect on how the patients sense of meaning-making. Meaning-making can exist in fruitful reflections about an individual's religious orientation and practices outside of religious language or practice. Spiritual caregivers can provide guiding contemplative practice that listens for indications of the significant and/or the sacred in a patient's life, culture, or spiritual worldview.

However, spiritual care assessment strategies still greatly utilize religious language to assess a patient's wellbeing. For example, Nolan and Grossoehme exemplify this type of reflection in two published case studies in which it is not clear what the role of god's presence is in the patient's lives but in the case study assessment the authors reflect on how god/the transcendent show up in each case study.[62] Instead of looking solely through the an assessment that searches for the role of god/the transcendent I believe that spiritual caregivers can assess for the unnamed energy within an individual that brings them a sense of meaning, a sense of connection, and a sense of purpose. This may be through their experience of music, charity, or a

[62] See: Nolan, "'He Needs to Talk'"; Liz Bryson, et al., "That's great! You can tell us how you are feeling," in *Case Studies in Spiritual Care,* George Fitchett and Steve Nolan, eds. (London: Jessica Kingsley Publishers, 2018), 35-51.

memory that brings them peace. Contemplatively reflecting with the patients about the meaning within their experiences is a practice of spiritual care. Swinton writes, "the 'god' of the non-religious person may not be external but may revolve around a quest for that which is most significant to the individual."[63] This practice is set apart from the work of a therapist by the intention of the spiritual caregiver to help the individual voice, create, reconstruct, or grow their spiritual foundations within their daily lives.

In Rashida's case I attempted to assess how she was finding a sense of meaning from her Muslim faith. This was made complicated by the staff's belief, which I shared, that she may be attempting to manipulate staff by saying what she thought we wanted to hear. I was assessing her sense of meaning-making by asking her to think about her religion in a deeper way. In doing so we were able to discuss how her sense of Allah's presence was supportive to her anxieties; how she would think about Allah's presence in times of difficulty or in her practice of meditation. This gave specific language to where she finds meaning in her religion. She then went on to say, "I just need to do whatever my mom says," which does not represent her deeper sense of meaning but rather an attempt to please her mother and keep doing what she feels she needs to do. While I support patients working with their parents and respecting their parent's desires for them, my focus tends to be upon an individual's understanding of their own meaning-making and the way in which it supports their spiritual health. Sometimes this focus can take the role of co-deconstruction of religious beliefs. Bidwell writes,

> Deconstruction alone is not sufficient. It must be followed by a reconstruction of belief by exploring how different assumptions about God, faith, and prayer might lead to different spiritual experiences…it can allow [patients] to consciously choose the beliefs that will shape their relationships with God and other people.[64]

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[63] Swinton, *Spirituality and Mental Health*, 134.

[64] Duane R. Bidwell, *Short-Term Spiritual Guidance* (Minneapolis: Augsburg Fortress, 2004), 61.

My attempts to get Rashida to articulate the meaning within her religious orientation, while also challenging her full commitment to her parent's understanding of religion, was a way of encouraging Rashida to consciously choose her own meaningful beliefs within her own meaningful relationships. It can be argued that it would just be easier for Rashida to go along with her Mother's beliefs and find benefits from that. However, since Rashida was previously engaged in the reflexive process of shaping her sense of spirituality I interpreted this type of commitment as a letting go of her own sense of meaning or her own needs, which was a pattern in her family systems.

In a similar way, though not focused upon religion, I worked closely with Michael's sense of meaning-making. Michael and I focused upon music as a central part of how he makes meaning of his emotions, lifestyle, and relationships. Music is not only a deeper area of connection and meaning for Michael, but it is also something which he understands well amid a cognitive learning disability. As Michael would talk about his writing, I worked to encourage his reflection of how his writing can be a resource for his own story. In other words, a resource for how he articulates his narrative of meaning. While Michael voiced an interest in god at the end of our final encounter, his primary work at this point is finding his voice through his music and reflecting upon ways that he can reclaim his music to represent his narrative of meaning and contribute to his healing process.

Working with Sara I engaged a practical sense of meaning-making focused upon her interpretation of the usefulness of the hospitalization (i.e. just in it for new medication and all other things are pointless). Sara's interpretation of the unit's ability to provide her support is not directly related to her spiritual sense of meaning-making. However, the practice of being heard in her anger, a listening presence willing to hear and reflect upon her anger, provided her with an

experience of being validated and supported. Arguably, while this encounter may not have involved specific spiritual assessment, it can be precisely the role of the chaplain to listen, reflect back, and co-imagine what usefulness she may find on the unit. I often meet with patients who are experiencing non-symptomatic anger, or sometimes treatment exhaustion, to reflect upon the difficulty of losing oneself in the process of treatment. This was of primary concern for Sara on her fifth hospitalization questioning what beyond a medication change would be able to benefit her challenge with how she felt inside.

Spirituality as Connection

The Puchalski definition lists off areas of connection that may contribute to an individual's sense of spirituality including connection to themselves, others, society, and nature. An individual's sense of connection is deeply connected to their sense of meaning and sense of self. The adolescent developmental period offers unique opportunities for reflection concerning an individual's connections to themselves, their families, their environment(s), their beliefs, and themselves.[65] When seen as a developmental stage full of opportunities for growth and connection, caregivers can provide guidance, direction, and companionship in the reflection that creates opportunities for growth and healing.

For example, Michael finds a sense of meaning through writing lyrics and creating music. In paying attention to the meaning he is creating we noticed an opportunity for him to use his music not only to express his anger but also to express *himself*, and to articulate who he wants to

[65] See: Miller, *The Spiritual Child*, 207-232; Alice Graham, "Identity in Middle and Late Adolescence," in *Human Development and Faith: Life-Cycle Stages of Body, Mind, and Soul*, Felicity B. Kelcourse, ed., 2nd ed. (Missouri: Chalice Press, 2015), 231-243; Daniel J. Siegel, *Brainstorm: The Power and Purpose of the Teenage Brain* (New York: Penguin Random House, LLC., 2015), 1-37.

be. By articulating who he wants to be he may find a deeper sense of connection to who he is already. Therefore, interventions that provide reflection on his connection with his personhood can give him insight into how he is able to express his self. Therefore, connecting him with a sense of values and purpose. Music is his way of feeling connected to who he has been and who he wants to be. His music and writing have the potential to motivate him through difficult moments of healing and self-discovery all while writing, creating, and expressing who he wants to be.

Sara struggles with connection in the hospital unit. I believe that her disconnection in her home environments could be contributing to her treatment exhaustion. One of my goals with Sara was to help her to see a connection between what the unit had to offer her and what she wants for herself. I believe that this development of self-agency would provide her with a sense of connection even when other forms of connection are lost. I had hoped to work more with Sara concerning her self-esteem issues. I believe that her continued self-esteem issues, including shame and guilt, are also contributing factors to her disconnection with the potential of the hospitalization and therefore her decisions to avoid groups and treatment processes.

Rashida is presently discerning what type of connection she wants to have with her family. In one visit she spoke about a need for balance between herself and her mother. She articulated her need for her individuation. However, in a later visit she started to articulate a desire to just do whatever her Mom recommends. Her sense of connection to her religion, her family, and to herself is in process and I believe that she would benefit from further support regarding these areas of connection. Through an increased ability to articulate her sense of connection to herself, others, and her religious narrative she would be able to further step into a fuller sense of herself.

Additionally, a primary concern for Rashida is her disconnection with her three-year-old brother. Rashida was three years old when she suffered sexual abuse from a family member. Now that she is separated from her brother, who she treated like her own child, she had been experiencing reoccurring and frequent flashbacks from her own trauma. The psychiatrist was concerned that this compounded disconnection was a contributing factor to her hospitalizations. In consultation with the psychiatrist I decided to offer grief education and provide space for her to reflect on the significance of her brother in her life. I did not, however, provide deep reflective conversation regarding her brother due to the severity of the symptomatic responses she was having when she thought of her brother. I was able to hear about her relationship with her brother, about ways she practices thinking about positive memories, and validate ways she supports her wellbeing when she is missing him or worried about him. This level of discernment regarding what interventions would be beneficial or not, is a necessary role of any mental health chaplain working with pediatrics or adults.

Spirituality as Individuation

Individuation, though not mentioned by the Puchalski definition, is support of an individual's understanding of their personhood and their agency. Individuation supports a person by providing the grounding for a reflection on a person's sense of spirituality. Since individuation is about the *self* it presents a challenge concerning who on the team should focus on it. Is individuation the role of the therapist who seeks to understand the complexities of the family dynamics and individual's story? Is it the role of the psychiatrist who assesses an individual's psycho-social history in order to provide them the most thorough treatment? Or is it the role of the spiritual caregiver who attempts to co-create insights into the individual's power, agency, and self-worth? I believe that individuation is not up to one discipline but it is the role of

the entire team to consistently draw a patient's awareness back to their own individual healing. How each discipline provides this assistance may differ in practice, but the entire team works to provide connection to a person's individuation as a way of stabilizing a patient into their own experience of life, illness, and healing.

Lisa Miller writes on the concept of "Spiritual Individuation" as a form of individuation that often goes without notice. She writes,

> Spiritual individuation is the personal determination of spiritual views: about the self, about fellow human beings and reality, the me-or-not-me assessment, all of which the teen evaluates through inner experience, but now through a spiritual lens…. spiritual individuation is the adolescent's drive to find deeper personal meaning and purpose, in himself and in life.[66]

It is through a deep level of uncovering the self that an individual can differentiate their sense of wellbeing amidst family, school, developmental changes, mental health problems, substance use, and more. Miller goes on to argue that a disconnect within an individual's spiritual individuation leads to an inability to feel connection with transcendence.[67] Miller provides a helpful definition of what it is to feel transcendence. She writes, "to feel transcendent is to know our selves beyond the limits of the physical or ordinary self, as part of the greater universe."[68] It is the patient's sense of individuation that opens the opportunity to a deep connection to self, in the process of their spiritual individuation. In my experience, this spiritual individuation is uniquely important for adolescents as the adolescent stage of development is centered around identity formation. Therefore, while individuation is an important area of focus for adult patients, it can be crucial to an adolescent's formation mentally and spiritually.

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[66] Miller, *The Spiritual Child*, 211.
[67] Miller, *The Spiritual Child*, 221.
[68] Miller, *The Spiritual Child*, 53.

In practice, individuation is articulated through the words of the patient and supported by the work of the spiritual caregiver. It is a co-imagining of themselves that provides insights into their present illness narrative and their agency in their overall healing and wellbeing. Utilizing Dialectical Behavioral Therapy skills, I attempt to highlight an individual's agency through my work to encourage their role in their own healing. I have experienced several patients, similar to Sara, who stop participating in the treatment programming because they do not see themselves in it. Sara said, "This is my fifth inpatient stay, [residential treatment] will be my sixth if they were helpful then I wouldn't be in here." She believes that there is nothing that can be done other than an adjustment of her medication. While adjusting her medication proved helpful, our discussion centered around trying to find herself. She later noted, "There is something bad inside me. Something bad that keeps coming back." Whether the "something bad" is symptomatic, based in her self-esteem, or something else I believe that it shows a continued disconnection with her spiritual individuation. Therefore, I encouraged her to pay attention to her spiritual health as a way of paying attention to her needs and feeling a deeper sense of connection to herself. She responded well to this and according to the chart attended unit programming starting that evening and through the weekend.

Rashida's spiritual individuation was rooted in her discernment of her religious narrative. She had a meaningful understanding of Allah as transcendent of peace in his presence. Beyond that she was exploring the way in which she identifies with her religion and how she is living into her embodied theology. I believe that Rashida could benefit from continued work in identifying her religious narrative as a part of her deeper self. I asked her, "What is it about your religion that brings you support?" in order to encourage her to reflect upon the individual nature of her religious beliefs. I do not believe that the perceived contradictions between her religious

beliefs in previous visits and her desire to believe and do whatever her mother advised, shows a necessary problem. In fact, I think it is common that patients will begin to contradict themselves over a period as they seek their individual sense of understanding. The reason why I agreed with the medical staff's interpretation that she was attempting to manipulate the staff had to do with her change in tone, the way she was answering questions or changing the subject, and her lack of depth to her answers when she had otherwise been insightful. Chaplaincy doesn't always engage in assessment for manipulation but occasionally PBHSC necessitates a heightened sense of observation as to whether or not the patient's reporting is accurate to who they are or who we (the care team) know them to be.

I experienced Michael as thoughtfully attentive to his spiritual individuation. He knew who he wanted to be and he was able to articulate that through his music. He told a story that highlighted a value for supporting others, in which he encouraged a younger man to not joke around with gang signs but to take learning and himself seriously. I believe that this value highlights one aspect of Michael's true self, which seeks to care for others and utilize his own voice doing so. If I were able to continue working with Michael I would focus on his continued articulation of his spiritual individuation and work to connect that to his surrounding treatment goals and mental health problems. It is also true that Michael finds himself in his writing and rapping, as he expresses both his emotions and who he aims to be through healing and recovery.

Spirituality as Integration

The last theme I want to reflect on is that of spirituality as integration. Integration is both the expression of an individual's spiritual self and the intrinsic aspect of how their meaning, purpose, connection(s), and individuation bind together. I believe that an individual's integration of their selves with their values, experiences, surroundings, and more is constantly being fulfilled

over time, adapting and growing throughout an individual's lifetime. Specific to the adolescent developmental period there are many opportunities for integration as an area for growth, an area of opportunity, and an area of risk.

Spiritual care assists in the dynamic journey of discovering new connections, articulating meaning, and creatively falling into one's understanding of themselves. Lartey explains that spiritual care, in whatever form, "may facilitate an ongoing process of self-discovery, engagement with others and a deepening and broadening of one's discovery of relationship to, and participation in, the transcendent and the world community."[69] Integration is the deepening of one's understanding of their transcendent self. When explaining this concept to the patients I work with, I attempt to simplify spiritual integration. I say, "Spirituality is learning how to pay attention. Pay attention to the way we see and experience the world around us and do (or don't) feel connected to ourselves within that world. And if you remember only one thing, remember spirituality is about learning how to pay attention." I believe that by simplifying an individual's understanding of spirituality as paying attention, I can begin to co-create with them understandings of the way they make meaning, understand their connections to self and others, their understanding of themselves as an individual and how they practice taking care of themselves. I support them through the development or validation of their integrated spirituality, returning to the practice of paying attention.

My job is to get adolescence to focus on themselves. Their deeply integrated spiritual selves. To explore with them how to notice, articulate, adapt, heal, and tend to the ever-adapting spiritual self. Swinton adds that "Spiritual poesis," the intersection between practice, theory, and interpretation, "moves us beyond the boundaries of concepts, categories and fixed definitions;

[69] Lartey, *In Living Color*, 151.

spiritual praxis locates care, not within the world of abstract concepts, but firmly within the life-world of people with mental health problems."[70] Integration binds an individual's spiritual understanding together while welcoming a simplified understanding of mindful awareness. I aim to teach individual's spiritual integration to encourage them to be in touch with their spirituality and their development of their spiritual wellbeing.

It is important to clarify that spiritual integration does not mean a settling into permanence of one state but a learning, adapting, falling into, discovering and re-discovering oneself. Doehring talks about integration as the embodied self within the embodied lived theologies that an individual may carry. Integration also requires flexibility and reflexivity. The abilities to self-reflect and create new understandings of meaning, purpose and connection throughout life.[71] These are difficult areas of reflection for individual's suffering from mental illness issues and chemical dependency, making this an important area of focus for a spiritual caregiver in PBH units. However, the difficulty also challenges the spiritual caregiver to validate and celebrate moments of integration even if they are only momentary. Practicing the integration of an individual's personhood with their behavioral health realities is both an intervention for single visits and can also be an overall goal of care. The themes of integration, meaning-making, connection, and individuation are not unique to the adolescent experience, rather it is the interventions within these themes and the challenges of the adolescent experience that causes these themes to shape the foundations of spiritual care outside of religion and within a spiritually integrated self.

[70] Swinton, *Spirituality and Mental Health*, 177.
[71] Doehring, *Practice of Pastoral Care*, 85-115.

Each of the case studies offer the continued work of integration that each patient is embarking on. Sara's primary work is to integrate her personhood into the medical narrative finding a space for her own agency in the care being provided to her and taking a role in her healing process. Michael is seeking integration through his music, through the ways that he articulates and expresses himself. Though he has primarily used this form of expression as an amplification of his anger, he is re-imagining his rap as a mode of self-discovery and realization. Rashida is experiencing dis-integration due to her family being separated, her being displaced from her home, and her memories of trauma. She attempts to integrate her needs for healing with her mother's expectation and the unit goals. Her efforts are great and may benefit her well but her continued difficult has been overlooking her own needs throughout the expectations and experiences of those around her.

When Spiritual Care is not Helpful

Throughout this project I have referenced moments when spiritual care is not beneficial within PBH settings. I believe that this is a unique challenge to PBHSC. First, it is important to remember the goals of the unit. On the unit discussed in this project the goal of care is to stabilize the patients (i.e. decrease their symptoms enough for them to return home or begin further treatment). At times, meeting a patient where they are to provide a supportive presence may invite further symptomatic difficult rather than support in stabilization. For example, a patient whose grief is the primary reason for their suicidal ideation may not, at this time, benefit from reflection of their grief. Another example is a patient who is spiritually or religiously fixated as a result of their behavioral health symptoms who is only further stimulated by a chaplain visit. A chaplain within PBHSC settings will benefit from critical reflection regarding the potential hindrance to care that spontaneous care can provide. Fitchett writes, "Assessment-

guided, goal-directed pastoral care is more likely than spontaneous care to have the desired or agreed upon effect and less likely to make matters worse."[72] As mentioned in previous sections it is in the heightened state of observation that PBHSC is strengthened and beneficial. Further reflection about mental health chaplaincy, and pediatric mental health chaplaincy specifically, as a specialization would do benefit the field greatly.

[72] George Fitchett, *Assessing Spiritual Needs: A Guide for Caregivers*, rev. ed. (Ohio: Academic Renewal Press, 2002), 20.

Chapter 5: Conclusion

The aim of this project has been to articulate the distinctiveness of PBHSC as opposed to general spiritual care. I made my case for the specialty of pediatric behavioral health spiritual care by first reviewing the literature available to this field. I discovered in my literature search that while spirituality is being researched and written about in increasing amounts, there are still minimal articles written by chaplains in PBHSC. I then presented three case studies, Michael, Sara, and Rashida to highlight unique aspects of PBHSC that differ from other areas of spiritual care in both intervention and assessment. I have hoped to communicate the unique opportunities within PBHSC and the potential benefits when spiritual care supports the developmental opportunities available to adolescents. To ground this work, I introduced and referred to Puchalski's definition of spirituality as a framework for spiritual care praxis. This definition encourages spiritual care practitioners to think about assessments, interventions, and outcomes within but also beyond the scope of religious care. It also provides a grounding framework for all current chaplain research if the researchers utilize the consensus definition as that which our certifying bodies has agreed upon, and if they are clear in their methodologies about how they define the framework of spiritual care to their patients.

The cases in this study are not generalizable to PBHSC or to mental health spiritual care, though the themes within the case studies may inform further theoretical development and research. I have intended for this project to inspire critique, reflection, research, and publications in mental health chaplaincy, non-religious centric spiritual care, and in PBHSC to further the foundations of literature available and to further contribute to a field that is of clinical practice that is committing itself to discovering methods of evidenced-based healthcare practice.

The three case studies, Michael, Rashida, and Sara are unique compared to the 29 published case studies but are not unique to my experience. I chose these three case studies as they represent my experience in PBHSC well. They bring together the patterns of patients with minimal religious orientations, minimal request for support, and spiritual care that goes beyond religious care while staying intentional about scope of practice. I also learned from these three case studies the intricate differences between the themes of meaning-making, connection, individuation, and integration. The reflection of each theme within the framework of Puchalski's definition allowed me the opportunity to analyze the clinical value of each theme for patients on a stabilization unit and to begin to articulate methods for assessment, interventions, and outcomes. I believe that future research would benefit in further articulation of interventions, assessments, and intended outcomes for the spiritual wellbeing of PBH patients. Similarly, these three case studies provided reflection for an assessment framework that I have created and utilized in my experience as a chaplain. The assessment questions are: 1) What brings you peace? (i.e. coping skills, spiritual practices/rituals, etc.) 2) When/where do you feel most connected to who you are? (sacred/valuable places, reflections on connection/integration, identity development, etc.) And 3) What, if anything, motivates you to be the best version of yourself? (i.e. higher power, family, self, god, etc.). These questions have guided many of my individual sessions and some of my group curriculum. They have the potential to guide my conversations towards needed areas of growth within a patient's spiritual wellbeing. Even when I do not use the wording of the questions as seen above, I consider the framework of self-care/coping methods, connection/disconnection, and motivating forces within. These frames of reference have guided my work and I hope to return to them in another project to research the potential benefits and growing edges they possess as assessed by patients.

This project is an answer to the call to make our cases made by Fitchett in 2011, supporting the growth of literature that articulates what happens in the room when a chaplain supports a patient. These cases represent my practice and my continued growth as a spiritual care provider. It is the goal of this project to make the case for the distinctiveness of pediatric behavioral health spiritual care. I hope that this project would continue the discussion that Fitchett and others have been having for years.

Where Do We Go from Here?

The push for evidence-based chaplaincy is necessary for an assessment informed spiritual care practice that informs interventions and is measured by patient outcomes. The need for evidence-based care is even more important within PBHSC since it is a field of vulnerable patients discerning between their reality and distortions, life-giving and life-limiting theologies/spiritualities, and developing their integrated spiritual selves. This project does not provide evidence-based research but aims to highlight this specialty of spiritual care including ways that patients benefit from spiritual care, ways that they can be harmed by uninformed spiritual care. It also aims to highlight ways in which spiritual care competencies for PBHSC and all of mental health spiritual care should be created, reviewed, and supported. I believe that one way of supporting this need would be the development of a mental health specialization for board certified chaplains. Currently the association of professional chaplains has a specialization for palliative care and hospice chaplains that requires the chaplain show evidence of additional competencies and receive continued education in their field of specialty. I believe the same can be done and needs to be done for mental health chaplains in order to improve the quality of care we are providing and monitor the effectiveness of the care that is provided.

Regarding further research, there are extensive opportunities for further research in PBHSC and in chaplaincy in general. First, chaplaincy needs a stronger foundation of theoretical grounding to build its research upon. This begins with articulating the definitions that chaplains use to describe the spiritual care being practiced and researched and to describe the different elements of spiritual wellbeing. This process of theory development is not in order to limit what spiritual care means but to provide frameworks in which specializations can both articulate and assess the interventions, assessments, and outcomes that may benefit their patient populations. Chaplaincy is at a unique time in which competencies and educational training are being challenged and updated from the Christian-centric foundations of chaplaincy. As the foundations of spiritual care are clarified caregivers can contribute to the field with similar definitions of spirituality, religion, interventions, outcomes, and assessments. A common language and spiritually reflexive foundation would greatly benefit spiritual care.

Further, the field of PBHSC would benefit from the continued expansion of case study publication, and clarification as to what happens in the room. More cases and voices of spiritual care professionals would provide the field with groundwork to contribute research into the theoretical practice of care, gaining input from chaplains nationally and internationally. Beyond case studies, PBHSC would benefit greatly from quantitative or mixed research studies that analysis the direct benefits of spiritual care interventions and articulate patient outcomes.

Examples of such studies could include researching the effectiveness and feasibility of my three-question assessment framework across multiple units. This study would potentially provide groundwork for a brief assessment strategy that helps articulate the areas of spiritual need. Another study could be a quantitative research project that reviews the chart notes of patients to research whether or not patients who received spiritual care support had a reduced

length of stay or reduced recidivism rates. Assessing the benefit for those who received spiritual care support and those who did not according to the chart notes, length of stay, and patient's state of mind at discharge. Finally, I believe a study that reviews the effectiveness and feasibility of the spirituality group curriculum our chaplains use could provide evidence for group topics that benefit a patient's stabilization and overall spiritual wellbeing. At this point the curriculum used (roughly 40 different group topics) is based upon mine and my colleague's experience. However, the field of PBHSC would benefit greatly from evidence-based research into the effectiveness of such groups and the development of a spiritual care group curriculum that could be implemented by spiritual care givers in any pediatric behavioral health center, much like cognitive behavioral therapies or dialectical behavioral therapies are used at treatment centers nationwide.

Evidence-based methodologies are developing within spiritual care both nationally and internationally covering a broad spectrum of chaplaincy. This process has focused significantly upon palliative care chaplaincy but has encouraged all areas of chaplain clinical practice to increase competency levels for research literacy and research informed practice. This push requires chaplains to implement a level of disciplined analysis to their spiritual care that has not previously been requested. I believe that this level of analysis will be beneficial to the field of chaplaincy as evidence-based research continues to strengthen assessment, interventions, and outcomes in clinical chaplaincy throughout the development of frameworks for care. Progress for evidence-based care will require chaplains to continue to analyze and write about their practice through case study publications so that the intricacies of what happens when a patient is with a chaplain is not lost to the valuation of what outcomes were gained. It is a difficult but necessary balance to hold to nuances of spiritual care practice in the growth of clinical research studies: stories of a young man who finds himself in his rap, a young woman who discerns the value of

her religious narrative, and the many youth who can't, for any reason, see the connection between their hospitalization and their personhood. I hope that as chaplain research continues, evidence-based research will provide quality to the practice and case studies will continue to bring life and voice to the uniqueness of the stories within the practice of spiritual care.

Appendix A: Interdisciplinary Team Newsletter Articles

March 2016

Through Our Eyes: Some Thoughts and Feeling From
The Chaplains about the Young People we Serve

Last year on my birthday, my 15-year-old child was admitted to an inpatient unit here at Fairview. While cognizant of the procedures and the protocols, I was not prepared for the helplessness I felt when I left my kiddo that evening. That night, I looked at my child through new eyes as I watched my beautiful child struggling to be, to belong and to become. I watched as our family struggled with new questions about who we were and where we would travel together during this process. The greatest comfort I had during that week was that my child was being cared for by you and your colleagues who took the time to see the hope in my child's eyes. As your chaplains we think every day how can we extend the hope and healing. Here are a few things that we see …… Chaplain K.

Here are a few things that we see:

At the start of each spirituality group I notice curiosity looking at me from each individual in the room. At first a curiosity of defense: "Who is this guy? Why do I have to do this group? Does he know I hate the idea of god?" I see many adolescents who present themselves with a shield of self-defense and disdain at any mention of the word spirituality. However, as we begin to see each other, as stories are shared, ideas are processed, and hopes are dissected curiosity turns into eagerness. I see a room of adolescents eager to fill the room with their questions, ideals, and wonderments. With which I see opportunities to turn curiosity inward as, those who are willing, continue the process of healing and recovery. Through my eyes I see curiosity self-develop amongst my patients as sobriety invites them to further encounter themselves throughout their healing process. I see courage, endurance, pain, hope, and an eagerness to know and to be known. ------Chaplain Adam

When I look at these kids, what I see is a collection of stories beginning to form the narrative of their lives. As with all of us, some of these stories are painful, and some are touching; some are full of joy, and others of hurt and fear. Often these stories lack acceptance, purpose, peace, and hope. None of them lack courage. We have joined these kids as part of their story, and what drives me to show love and care and help them make sense of it all is one simple question: what role can I play that will give them the strength to keep writing this book? ----- Chaplain G.

When I first encounter an adolescent patient in need of mental health healing, I notice their eyes. Their eyes usually reflect the worlds of anger, fear, emptiness, sadness, shame, anxiety, loneliness, confusion, and more. Little by little as they engage in the healing process, I begin to see moments of clarity flash across their eyes and catch a glimpse of their resiliency and hope. Sometimes the moment is fleeting, and sometimes it feels like it will stay and spread nourishing roots. Each day I witness humanity in all its diversity and I am humbled and in awe of the human journey. My hope for each child that comes into our care is that they catch a glimpse of our

belief in their potential to heal and become the person they were meant to be; a person with eyes of strength, understanding, and kindness for themselves and others. ------ Chaplain M.

November 2016

Letter from our Chaplain Team!

The last few months have been busy and fruitful as we, your pediatric behavioral health chaplain team, better clarify and articulate how our work in spiritual health connects with and complements all that you as a behavioral health team are doing. Our team was asked to provide examples of our group work and explain how these groups are therapeutic and beneficial. During this process we were continually reminded of why our groups are important to each patient's treatment plan and we thought it helpful to share our conclusions. After all, we share the goal of providing excellent care for our patients.

Awareness, or mindfulness, is often the first step in cultivating a healthy self-concept, and that is one of the main therapeutic outcomes of our spiritual health program. Our groups have some common therapeutic goals: healthy self-concept, growing awareness of our various "lenses" (e.g. beliefs that contribute to meaning-making), increasing capacity to think abstractly, notice, and develop frameworks of belief, developing critical thinking to challenge unhealthy beliefs, and developing spiritual and mindfulness practices that contribute to distress tolerance, patience, peace, and positive/hopeful cognition. These groups focus on a variety of topics such as hope, shame/stigma, connection, resilience, and grief.

Going through a mental health or chemical dependency crisis can raise a lot of big questions, and our groups add another dimension with which to explore those questions. For example, in one group we spend time thinking about ways society pressures us to conform to certain physical or achievement oriented standards, and the ways in which we have a hard time reaching them. Then we look to our positive beliefs about the world and ourselves, and draw upon those to find compassion and understanding for perceived failings and mistakes. Often our spiritual, religious, or philosophical beliefs help us to be compassionate toward others, but we don't apply the same kindness to ourselves. Our groups help each patient/client think about and learn practices that can help them do so.

We see our work as complementary to the DBT and other clinical outcomes that the pediatric behavioral programs facilitate. Although the unique methodologies we implement as spiritual caregivers are different, our goals are the same. We strive to continue offering robust and holistic treatment for our patients, with the expectation that we can help children and adolescents cultivate peace, joy, hope, and overall wellness as they grow and mature.

Appendix B: Training Resource

The Differences between Disciplines *What are the core differences between spiritual care, therapy/psychology, and social work/care coordination in a hospital setting?*

****ALL these disciplines are forms of "Applied Empathy" and caregiving, but each have different means and goals****

	Spiritual Care/Chaplaincy	Docs/Nurses & OT, Psych Assoc.	Social Worker/Care Coord.
GOALS of care	• Assess health **of support systems, coping mechanisms**, & **worldviews** • Encourage **positive connection** with self, the Divine, personal agency and wholeness • **Integration of personhood** with goals of care/medical realities	• Stabilize medications in the context of **symptom improvement** (less depression, psychosis, etc.) • Improve problem-solving, socialization, independence, hygiene, self-esteem, sleep hygiene, goal-setting	• **Connect** pt to key resources for daily functioning • **Coordinate** with outside case management team, or outpatient services
Diagnoses and current symptoms…	FYIs for spiritual assessment, cautions for safety and red flags for conversation… **but we also want to have the pt tell us what it means to THEM to feel unwell**	**DRIVE the care plan** (mostly pharmacology & stabilizing psychology, not in-depth therapy)	FYI as far as specific resources that might be useful, restrictions as far as what living situations might work.
Primary Focus	**CONNECTION & INTEGRATION** (and *assessment* is a helpful companion)	**CLINICAL ASSESSMENT** (and *compassion* is a helpful companion)	**PROBLEM-SOLVING and NETWORKING** (*compassion and assessment* also key)
Conversational goals…	• **Exploring** meaning, purpose, divine-connection, spiritual strengths and needs • **Finding a good and healthy fit** between pt (as they are!) and the world (as it is!) • **Experiencing wholeness** in prayer, ritual, meditation, etc.	• Chart stabilization's progress, make plans, name outstanding needs • Ultimate goals for discharge is that pt feels better and any acutely risky symptoms are cured/managed	BUILD a SCAFFOLD of SUPPORT for pt's discharge (next steps, communication with outside assistance, place to live, etc.)
Role of Patient's personal history	• *Acknowledges* how personal history shapes present • **Does not delve deep**, but may carefully use the past to reclaim hope & strength, or name pain (should then be referred for further work in therapy, with trauma counselor, etc.) • **Focuses on moving toward the FUTURE,** the '*now what*' of goals, hopes, forgiveness, grace, etc.	• Explains motives and hang-ups • Informs diagnosis and treatment plan • In outpatient care, therapy may delve deep into past history to heal old wounds through intense analysis	FYI as far as pt's ability to follow up, financial and legal history, need for support and history of functionality outside the hospital.

Appendix C: Group Process and Worksheet

Would You Rather

Objectives

- Gain wisdom, insight, and support from one another (as appropriate) and from chaplain as the spiritual specialist.
- Increase patient's capacity to notice diverse beliefs in their life, family, and community.
- Increase patient's capacity to notice their strengths and practice affirmations.
- Gain tools and practice in reflective reasoning and goals of care discernment
- Create frameworks for healthy spiritual practice and understanding / challenging unhealthy beliefs with a background of affirmation and support.

Expected Therapeutic Outcome

- Patients will develop a sense of the diversity of beliefs concerning what their current needs are and how to articulate their needs.
- Patients have an opportunity to integrate treatment modalities through the lens of spiritual health.
- Patients will develop a sense of our various "lenses" (e.g. beliefs that contribute to meaning-making).
- Patients will develop a sense of reflection as a way of checking in with themselves and their needs.

Process

1. Explain that for group you will be asking a set of Would You Rather (WYR) questions. Note that since WYR questions can become very inappropriate you will be the only one asking the questions.
    a. There are three guidelines for the groups
        i. **No debating**. This is a group to practice listening to one another to see if you can notice similarities or hear different perspectives.
        ii. **Do not blurt out answers** but wait to be called on. Everyone will get the opportunity to share.
        iii. **Use "I" statements** in all of your answers speaking about your view and not speaking for others.
    b. There are no right answers this is simply of practice of checking in with oneself and one's current needs.
    c. Articulate that as a momentary check in these questions can have different answers based on time of day, mood, discoveries, frustrations, etc.
2. The questions are as follows (remind patients that these questions are focused on what they need *today*).
    a. WYR be the boss of your life or be guided through life

b. WYR be understood or understand
c. WYR be loved or love
d. WYR trust or believe
e. WYR stay put or move forward

3. Following each question help them process the answers briefly and attempt to analyze the benefits and challenges to either answer. For example, to be the boss of your life can be beneficial and give a sense of control and some healthy boundaries. And any *good* boss would, from time to time, check in with a council to make sure things are going well…To be guided through life is not the same as being dragged through life. If you want to be guided, great! But pick a good guide and be willing to disagree occasionally. Have either of you checked in with how it felt to be the boss? Or does anyone have a healthy guide in their life?
4. At the end of the group simply thank the youth for processing well and ask them if they noticed anything new or gained any new insight.

Discerning Your Spirituality

Spirituality = paying attention to how you see and experience the world and how you practice taking care of you.

What activities bring you a sense of peace when you are:
(name 2 activities for each emotion)

Angry:

Sad:

Anxious:

Energetic:

Disappointed:

What places or activities help you feel connected to who you are?

1.

2.

3.

4.

5.

What motivates you to be the best version of yourself?

If you could describe your spirituality in three words what would they be?

1.

2.

3.

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